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**Middlesex University and the Metanoia Institute**  
**Doctorate in Psychotherapy by Professional Studies**  
**DPY 5360**

**Developing an Intervention Psychotherapy Programme for the**  
**Needs of Iranian Immigrants in the UK**

**Submitted by Mitra Babak**

**Student No: M00287567**

**Date of Submission: 17/04/2015**

## **ACKNOWLEDGEMENTS**

I would like to offer my whole-hearted gratitude to my project supervisor for his limitless guidance; and to my clients for their trust, which has enabled me to gain a broad range of practical experience.

I am also grateful to my son, daughter and my mother for their encouragement and motivation throughout my academic studies.

Finally and most importantly, my thanks go to my dearest late father, who inspired and mentored me throughout childhood and adolescence. He not only taught me what to value in life and awakened a thirst for knowledge, he went against the tide in reassuring me that a female should and could achieve whatever she desired and that I should not be constrained by the opinions of others. I hope that he would be proud of how I have endeavoured to put his advice into practice.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**DECLARATION**

I, Mitra Babak, would like to declare that all the material of this study is solely my own work that has been performed without any aid. This work has not been submitted previously at any academic or professional level. The views represented in this study are my own and not those associated with this or any other university.

Signed \_\_\_\_\_

Date \_\_\_\_\_

## **ABSTRACT**

This research focuses on the mental healthcare needs of Iranian couples that have emigrated to the UK. There is a striking lack of research focused on understanding the mental healthcare needs of, or evaluating the quality of mental healthcare services available to, Iranians living in the UK. Western psychotherapists need to accept the role of clients' worldviews as critical to the efficacy of psychotherapy. All approaches to psychotherapy are culturally biased; traditionally available Western psychotherapeutic approaches are informed by Western culture. The Psycho-Educational Psychotherapy Programme (hereafter named 'PEP') was initiated in its rudimentary form when the researcher worked for the NHS. Regular one-to-one sessions with couples are an integral part of PEP, and they were included intuitively without systematic examination or evaluation. Interviews and focus groups were held with psychotherapists working with culturally diverse clients to investigate their views and experiences of working with Iranian clients. Most interviewees were dissatisfied with the high rate of disengagement of their Iranian clients. They reported their success rate with Western clients as higher than with their Iranian clients. Clients tend to be uncomfortable with therapists who cannot approach sexual issues from a cultural perspective. Thus, factors such as religion and education have an immense impact on clients' engagement, as well as on their expectations.

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## **CHAPTER 1: BIOGRAPHY OF THE RESEARCHER**

### ***1.1 Opening Comments***

I was born in Iran and have been conducting research on Middle Eastern culture for over 26 years. For the past 15 years, I have worked as a psychotherapist, during which time I have dealt with a large population of immigrant couples (both hetero- and homosexual) and discussed my clinical work on my weekly television and radio programmes. My final project explores some of the challenges faced by immigrants in psychotherapy, and also investigates the reasons why they disengage from therapy. Further, it explores what might constitute the most suitable mode of psychotherapeutic treatment in an immigrant population. This study emanates from both my research work and my practical experience as a psychotherapist.

Following is an introduction of my research focus and topic, the personal context within which I work, and the professional and socio-political context of this project.

### ***1.2 Personal Context***

I believe a person's professional aptitude and ability is as much a product of formal training as of life experience, personal beliefs, values and attitudes. For this reason, I feel it important to present my personal context, as it provides insight into the motivation behind my choice of topic. It also locates me as the researcher within the context of the research topic. In what follows, I present my personal history, which is inextricable from my current research.

The aim of this research is to evaluate, provide empirical evidence for, modify and improve my basic Psycho-Educational Programme (PEP), by using insights from the literature and by conducting research with psychotherapists. I have a private psychotherapy practice, in which I use my Farsi Psycho-Educational Therapy Programme (FPEP). This programme is the outcome of years of experience working with clients from Iranian and other Middle Eastern backgrounds. My work with this diverse clientele has revealed vast socio-cultural differences between clients from different Middle Eastern countries: clients from Afghanistan, Egypt, Iraq, Lebanon, Syria, and Iran, though sharing an overarching cultural heritage, are far from homogeneous. Such differences manifest themselves in what clients expect of mental health programmes, how they perceive things, and sometimes even in their inhibitions.

Growing up, my main inspiration was my father. He was always respectful, supportive, and encouraging of my interests. As a teenager, I became interested in the social problems around me. These included drug abuse and alcohol addiction, but also cultural tension, religious persecution, and political conflict, all of which were rampant in Iran during that period. I became interested in researching these issues, and spent hours talking to people to understand their attitudes, beliefs and thought processes. My father helped me understand some aspects of the region's geopolitics as well as factors influencing the complex makeup of Iranian society, which illuminated the root causes of numerous problems I witnessed daily.

I was involved in the political demonstrations against the Shah, and was once shot and almost fatally injured. In 1979, after the Iranian revolution, I participated in the

counter-revolution against Ayatollah Khomeini because I felt the ideals of liberty and freedom had been damaged. During these turbulent times, I married and moved to Syria. Here, I continued my research on different cultures and learned more about how culturally diverse people interact, as well as about the socio-cultural dynamics such interactions engender.

Whilst pursuing my degree in business administration, I studied different languages, including Arabic and different Kurdish dialects. This was crucial to understand the different cultures I encountered in Syria and, later, in other parts of the Middle East. My multi-lingual abilities have been most useful in my work as a psychotherapist. I believe that by speaking with clients in their own language and thereby demonstrating an understanding of their cultural values and beliefs, it is possible to establish a deep trust.

My interest in different cultures gave me a new perspective on life. One is born into a culture by chance. As an adult, however, one has the freedom to adopt one's own belief system. My personal belief system became an eclectic, flexible combination of the diverse socio-cultural value systems I had come to know. This made me more tolerant, accepting and open about the views of others. It has assisted me in my profession. I believe that my clients perceive me as a flexible, non-judgmental psychotherapist, and that this makes it easier for them to connect with me.

Various life experiences have led me to intense introspection — the untimely death of my beloved father; two messy divorces, which left me financially and emotionally shattered; my mother's cancer diagnosis and her complete financial and

emotional dependence on me. I also have health issues, with which I battle each day. I have had three spinal operations and suffered a blockage in the left occipital cortex of my brain; this is inoperable owing to the risk of blindness, amnesia, or even stroke. I have an MRI scan every year. Through each difficulty, each trauma, I have grown as a person and have become more empathetic towards others' problems. My personal struggles with grief and pain have made me more humble and humane; characteristics that I assume help me in empathising with my clients and in gaining their trust.

While in Syria, my interest in different cultures, languages, and people was solely personal, not professional. When I immigrated to the United Kingdom in 1991 and started working as an interpreter in five languages, I considered pursuing a career in psychotherapy. I realised that there was a shortage of Middle Eastern psychotherapists, counsellors, and psychologists in the UK. There were very few mental health professionals who could understand Middle Easterners and Middle Eastern culture. When in psychotherapy after my second divorce, I spent many sessions with my English psychotherapist explaining my culture, trying to make him understand why my divorce alienated me from my own mother instead of causing her to support me. I decided to become a psychotherapist, and enrolled in a Master's course in Psychotherapy at the University of East London.

My thesis was titled *The role of cultural background in psychotherapy as perceived by clients*. It provided insight into how cultural differences between therapist and client can influence the efficacy of psychotherapy. The results led me to focus on how clients perceive therapists and, later, to develop a psychotherapeutic approach aimed

at creating trust and safety for clients. I now use this approach in my private practice the psychotherapeutic programme is discussed in the next chapter.

In 1997, I began work as a voluntary counsellor for governmental and non-governmental organisations. I also worked for the Ethnic Alcohol Counselling in Hounslow (E.A.C.H) project. By 2001, I was working with couples, groups, and individual clients at the West London Mental Health NHS Trust. In 2004, I developed a programme called the Middle Eastern Family Counselling Service in Ealing (MEFCSE), for Farsi, Arabic, and Kurdish speaking clients living in Ealing. The MEFCSE was part of the Choosing Health funded project, managed by Ealing Primary Care Trust (EPCT).

The MEFCSE programme included psychotherapy for women-only groups, for couples in groups, and for unisex groups. The aim of MEFCSE was to benefit clients through counselling in their own language and in a culturally appropriate environment. The service offered a 16-week course, during which groups met twice a week. The sessions focused on integrating Middle Eastern clients into their new culture. Cultural differences, associated internal and external conflicts, family dynamics, relationships and sexual problems were explored. Each session introduced a new topic; 16 topics were covered in all.

Marital and sexual issues appeared to be of greatest concern amongst these clients. Through this experience, I developed greater sensitivity. I learnt to approach clients with sympathy and patience, especially when dealing with painful personal issues such as family feuds.

Both the MEFCSE and FPEP were successful and received positive client feedback. During the six years I worked with the MEFCSE (2004-2010) and my ongoing



work with FPEP since 2007, the participant rate rose steadily. The popularity of the seminars suggested that people from Middle Eastern cultures might require longer, more interactive, and perhaps more intensive therapy. Weekly seminars provided clients with a platform to role-play and to learn about themselves and others, helping them to accept painful aspects of their lives and move forward. Based on this, I hypothesised that short-term therapy, in which sessions are limited and conducted individually, might not have maximal efficacy with the Middle Eastern clients I was seeing in the UK.

By 2010, I had prepared a series on 'Struggling with fear in civil disobedience, social psychology, and culture from a Middle Eastern point of view' for Satellite Persian television (PARS), and another entitled 'Post-natal depression (PND)' with the BBC. I became an active contributor to Keyhan, an Iranian International newspaper, writing on the topic 'dealing with loss and anxiety'. In addition, I began weekly appearances on live television and radio shows related to mental health issues encountered by Middle Eastern individuals, especially Iranians. By this time, I had established my own private practice, which demanded a great deal of my time. Unfortunately, I was not granted adequate funding or staffing support by the NHS, and had to disband the MEFCSE at the end of 2010.

During my work with MEFCSE and FPEP, I realised that these programmes were attended by an increasing proportion of multi-cultural clientele, who either had already explored different mental health facilities, or had been referred to me by colleagues unable to engage with the clients. The reasons given by my colleagues for this lack of engagement were not only their own difficulties understanding the clients' cultural,

religious and belief systems, but also the clients' difficulties engaging with psychotherapy. My colleagues frequently asked me to conduct workshops to help them understand Middle Eastern culture, and to suggest suitable approaches that might help them penetrate their clients' experiences.

In June 2013, I conducted a workshop in Ealing based on my doctoral research. My colleagues found this interesting, and asked me to present more workshops about my research in the future. Some of the topics I discussed are outlined below, as these serve as the rationale for conducting the current research:

### **UK: A multi-cultural society**

The United Kingdom (UK) is a multi-cultural society with people from different parts of the world living together. As of the census survey of 2001, 8% of the total population consisted in diverse ethnic minorities, and is projected to increase to 20% by 2050. Of the ethnic minorities, the Middle Eastern group constitutes over 100,000 individuals, according to an independent estimate. There are no specific categories for Middle Eastern groups and for several other groups in the census format; these estimates are thus independent projections by experts. It is clear, however, that the UK is becoming increasingly multi-cultural.

### **Mental Health Needs of an Increasingly Multi-Cultural Society**

One outcome of the increasing trend towards multi-culturalism in the UK is that many immigrants experience difficulty adjusting to their new environment. There are vast cultural differences between the Middle East and the UK. In my own practice, I have

found that marital dynamics constitute a major pressure often exerted on the immigrant population on immigrating to the UK.

Following is a discussion of some of the problems I have encountered in my practice.

### ***The patriarchal nature of Iranian men***

Iranian men are brought up in a culture of male superiority, in which challenges to male dominance — both within their marriage and outside the home — are unacceptable. In general, they dislike it when their wives demand anything of them, and they may not like working under a female boss. This may lead to isolation, confrontation or even domestic violence.

### ***Changing Roles and Expectations of Women***

Living in the UK, Iranian women may take on additional responsibilities, such as driving and meeting people, helping children with their schoolwork, and earning a living. With greater independence and empowerment, women expect to be treated with greater respect, and expect equitable treatment in their home. If they continue to repress these needs, they may suffer depression or other mental health issues.

### ***Sexual Issues***

In Iranian culture, sex is a taboo. There are various misconceptions about sex, such as, women should not enjoy it and that they should submit to men's wishes. Many of my clients have little knowledge of the female orgasm, thus many have never experienced sexual satisfaction. Men and women tend to perceive sex differently, which may cause psychological problems.

### ***Arranged Marriages***

In the arranged marriage system followed by Middle Eastern and some Asian communities, couples may not even have the chance to interact before being married. Often, the man returns to his native country and brings a bride back to the UK with him. In these cases, it is only after the wedding that they discover their spouse's personality. This may be a shocking experience for them, leading to marital discord and depression, amongst other issues.

### ***Marriages Made for UK Citizenship***

Marital conflict often arises when people marry someone with British nationality as a means of escaping their own country. This, too, may lead isolation, distance and divorce, as well as associated mental health issues.

### **Reasons for Disengaging from Therapy**

Ethnic minorities are more likely to have poor outcomes when treated for mental health issues, and often disengage from mainstream mental health services (Mental Health Foundation, 2011). This may be attributable to various factors:

### ***Lack of Understanding of the Concept of Therapy***

The collectivist Middle Eastern culture, where relatives and friends solve family matters, does not encourage seeking professional therapy for personal problems. Couples living in the UK, however, may not have access to extended families and may therefore

feel isolated. Further, in the community, the idea of needing psychotherapy has a negative connotation. Thus people simply avoid going to a therapist.

### ***Fear of Being Judged by the Therapist***

Immigrants, especially men, are afraid of losing face in the eyes of therapists, owing to the patriarchal system within which they have been raised, and to thinking it taboo to seek mental health.

### ***Lack of Openness about Sexual Discussions***

In traditional Muslim culture, any discussion of sex-related topics is discouraged. Thus clients are hesitant to discuss their sexual problems.

### ***Lack of Faith in Western Therapists' Ability to Understand their Perspective***

Therapists are sometimes considered 'aliens' who know nothing of Middle Eastern culture. Thus clients may discredit their ability to help, from the onset. Further, people may expect therapists to take responsibility for the difficulties they are experiencing, and to provide quick-fix solutions.

### **Client Expectations and Different Therapeutic Approaches**

In August 2013, I organised and presented a seminar in Norway (in Stavanger and Oslo). On the 28<sup>th</sup> of June 2014, I was invited by the Iranian Cultural Society in Liverpool (ICSL) to attend a one-day seminar for professionals, at which the general

public was also welcomed. The subject was immigration and the difficulties of adjusting to a new culture, with special reference to how this may affect couples. Possible outcomes of immigrants' mental health difficulties were also discussed.

I discussed the poor outcomes of ethnic minorities in response to treatment for mental health issues. I talked about how this may lead to disengagement, owing to a lack of understanding about and acceptance of the concept of therapy, a fear of being judged by the psychotherapist, a lack of openness about sexual issues and expectations that the therapist will take responsibility and will provide a quick-fix solution, but also, importantly, to a lack of understanding of the client's culture on the part of the therapist

In addition, I discussed some of the reasons why people emigrate—an important issue in psychotherapy. I also discussed some of the reasons behind the increase in divorce rates, and some of the differences between emotional, social, family and religious ideas about divorce. I argued that the leading cause of mental health issues and divorce in immigrant populations is difficulty adjusting to a new culture, which often exerts a negative impact on marital life.

Participating in these workshops and seminars made me realise the need for a stronger cultural-based element in the education and training in psychotherapy. During my own psychotherapeutic training, there was no focus on the cultural background of the client. My focus now is on not only the delivery of psychotherapy but also on psychotherapeutic training.

Research reveals that Western psychotherapy tends to focus more on clients' personal issues than on the complex culture-specific perceptions they may have. There

are exceptions. In recent years, some psychotherapy training programmes have focused more on culture.

My Middle Eastern background and my consequent intimate understanding of the differences between Western and Eastern cultures have made me conscious of factors that may undermine the psychotherapeutic process with culturally-diverse clients, including Western-trained therapists approaching people from different cultures with the traditional approach. Conventional Western psychotherapy does not consider cultural aspects, focusing rather on therapeutic facets.

To some extent, I gained deeper insight into issues of Middle Eastern diasporas through additional research and preparation for my weekly television programme on ‘Monato TV’, on which I discuss psychotherapy and cultural issues. Additionally, my live radio programmes on Radio Omid Iran and Radio Azadegan (a satellite radio station based in Stockholm)<sup>1</sup> help me connect directly with Iranians, which has allowed me to familiarise myself with their problems and the struggles they face living in Western society. Both these programmes have allowed me a direct glimpse into people’s psychological and social problems.

*The Mitra Babak Show* was a psycho-educational drama documentary programme that aimed to help analyse everyday situations in a simplified way. The programme was spread into six episodes, each examining a different scenario. The scenarios I set up were based on the most common situations that immigrant couples come face to face with. I helped the actors (weekly seminar members) by giving them detailed briefs about their

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<sup>1</sup>I have also been invited to present on some other satellite television channels, such as Pars and Andiseh.

characters, background information and dialogues about the role they played. The *Mitra Babak Show* programmes were widely watched, firstly as they were in Farsi, although each episode did have subtitles, and secondly, because they were available on Youtube.

During International Refugee Week in June 2014, I set up two intensive seminars in partnership with UK-based charity Rescue 4 Children, who operate in Syria, Iraq, Kurdistan and Turkey. The seminars were designed to invite immigrant couples from various Middle Eastern countries including Iran. The content of both seminars was to help analyse issues that immigrant couples and families commonly face, and ways in which they could understand and overcome them in due time. Both of the seminars were very successful; from the feedback I received I realised that the attendees were unfamiliar with such psycho educational programmes, as well as not having been able to discuss their situations in their own languages before.

A third event was co-organised by myself and Rescue 4 Children charity held at the Rio Cinema in London on the 28th March 2015. The seminar was based on the extensive work carried out by the volunteer staff who work with refugee and displaced families and couples in the various refugee camps. The seminar was based on a two hour training programme I planned to help the volunteer staff understand underlying issues about couple therapy, role play and the difficulties immigrant, refugee and displaced couples commonly face. Guests from the wider public were also invited to also engage in the programme. I highlighted the importance of languages, different cultures and the benefits of the psycho-educational programme.



PEP has been successful. An increasing number of satisfied clients have attended over the years. It has evolved into a broad framework, which I use flexibly with clients from specific cultural groups. I appreciate, however, that an individually developed, experience-based programme such as this requires systematic evaluation and validation. The current thesis attempts to fulfil this task. The seminar programme represents a basic model, to be enriched and validated by the insights I have gained from the empirical literature, as well as from my research of psychotherapists with Iranian clients.

### ***1.3 Professional and Political Context***

My research is embedded within a professional and political context. Furthermore, it is located within the wider framework of policy development to promote ethnic and cultural equality in the UK healthcare system. A great deal of healthcare policy as related to ethnic or cultural diversity appears politically motivated, in a positive way: there is scope for developing individual, culturally targeted programmes. Nevertheless, I am uncertain whether my proposal to prioritise a culture-based approach to healthcare would be accepted and implemented by policy makers. I anticipate resistance from other psychotherapists and perhaps even from political authors, who may perceive culture-based psychotherapy as a threat to the status quo. I believe, however, that my research could be instrumental not only in helping therapists conduct more effective psychotherapy with Iranian clients, but also in encouraging other researchers to develop culturally-compatible programmes.

### ***1.4 Overview of the Final Project Work***

Following is an introductory chapter, a review of the literature, and a discussion of PEP. Thereafter, the research approach is outlined, including the epistemological and philosophical stance of this work. Data analysis and research findings are presented, followed by a concluding discussion.

### ***1.5 Ethical Considerations***

As mandated for research with human subjects, this study duly considers ethical responsibilities and requirements. Informed consent was obtained from all interview respondents. In the case of interviews, consent was obtained in two steps: first from the centres, and second, prior to the interviews, from the selected psychotherapists.

Informed consent was obtained for the focus group, by providing participants with full disclosure regarding the aim of the research and the purpose for which the information collected would be employed. In the case of the focus-group participants, as their input was to be obtained with the aim of improving the Modified PEP module, it was deemed necessary to invite them to participate in post-research training on the Modified PEP module so that they could employ it in their own practice. The final version of the PEP is to be used by the researcher in her own private practice, and, at a later stage, as a psychotherapy training package for interested centres, government hospitals or individual psychotherapists. Hence, a certain monetary outcome was expected from the research findings; it was therefore believed that offering free training for the focus-group participants was ethically mandated.

In addition, all participants (the 20 interview respondents and five focus-group participants) were assured of their safety during the research process. This included making the participants aware of the process by which data collection was to be performed and the location as well as setting of data collection. The respondents were assured that there would be no threat to their personal safety during the course of the research and that they were free to withdraw at any time and for whatever reason, without being required to provide a reason.

Another ethical consideration was the maintenance of confidentiality. Participants were assured that neither their names nor those of the centres with which they were affiliated, would be disclosed anywhere in the final research report. All data obtained was used for analytic purposes only, and was not disclosed to any third party. The personal and demographic information of the participants was kept private. In this manner, it was possible to maintain confidentiality and to protect participants from third-party intrusions of any kind.

The data collected from the respondents during both interviews and focus-group discussions, was recorded and stored with diligence, to ensure that the integrity of the data would be maintained. The interview data was tape recorded with the permission of the respondents, ensuring that the information would be available in its original and accurate form. Further, the two sessions of the focus groups were videotaped with the consent of the participating psychotherapists. Both types of recordings were kept safe and used only to refer to the material as and when needed during analysis.

Findings based on research involving clients under psychotherapeutic care present special ethical dilemmas, which require careful consideration. The researcher carrying out such investigations should be acutely aware of issues such as counter transference during the research process (Holmes, 2014); potentially muddled boundaries between clinical psychoanalysis and research interviews (Holmes, 2013), especially given the fact that contemporary interview methods are derived largely from older literature on the psychoanalytic interview (Kvale, 1999); the issue of differentiating clinical and empirical research in psychoanalysis (Leuzinger-Bohleber & Fischmann, 2006); the problem of interpreting qualitative responses in the research setting (Holmes, 2013) and, closely related to this, the fact that findings are 'co-constructed' in qualitative research (Duggleby, 2005), but that this neither renders ethics relative or open to interpretation, nor rules out the application of a strict ethical code in such research. Even though a large part of this research involved interviews with psychoanalysts themselves, they nevertheless were reporting on their psychotherapeutic experiences with clients, and the aforementioned points are therefore just as, if not more, relevant. Care needs to be taken in a research study of this nature to, as far as possible, distil the objective data from the mode of data collection, whilst understanding that the kind of data being obtained is of the most subjective kind there is and, furthermore, is not being obtained from the subjects themselves, first-hand. The nature of the empirical evidence in qualitative studies therefore differs from that obtained by quantitative means. When confronted with data that is inherently subjective in nature, the only solution is to analyse it as systematically and thoroughly as possible, whilst remaining sensitive to its depth of meaning and

attempting to compromise this as little as possible. Qualitative data is important *because* it is meaningful.

Furthermore, issues related to interviews and focus groups should also be considered. Some common ethical concerns in interview research include reducing the risk of unanticipated harm and exploitation; ensuring confidentiality and anonymity of interviewees, as well as the protection of the information they divulge; and ensuring that participants are fully informed of the nature and purposes of the study and that they understand its aims, implications and potential research products or outcomes (DiCicco-Bloom & Crabtree, 2006). Considering the first of these points, interviews may cause interviewees to engage with material, which in some way upsets them, and has up until that point remained unexamined. In such cases, harm may arguably be said to be done to interviewees in that they may not have been prepared or had the mental or emotional resources with which to confront such material. The researcher should have a system in place to offer psychological support and treatment to participants in the event of the need arising.

Second, the information shared by interviewees must be protected not only out of principle but in order to prevent any adverse effects if the information were to compromise an interviewee by conflicting with the interests of anyone in their professional field, for example. In the case of the current study, there may be opposition to challenging currently established ways of conducting psychotherapy with culturally-diverse clients, and the opinions of interviewees, whose ideas might run counter to the

prevailing ideas in the field, should not in any way jeopardise their standing by somehow being associated with them.

Third, because of the way data emerges in interviews, and the sometimes unexpected nature of the information that may emerge, consent to research should, if possible, be confirmed at a few stages throughout the research process, and participants should be reminded that they have the right to withdraw from the process at any point. Ethically, interviewees should always be acknowledged for their contribution to the research outcomes, or should 'benefit' in some other way.

A central ethical concern is whether the research contributes more to enhancing personal freedom or gain for the participants, than the career of the researcher (DiCicco-Bloom & Crabtree, 2006). In the current research, this question is not as straightforward, because the participants are not the clients under psychotherapy themselves, but rather psychotherapists commenting on such clients, whom they have treated in their practice. This complicates the ethical dilemma, since the research data is emerging from psychotherapeutic material, but second-hand. It places great responsibility not only on the researcher, but also, in this case, on the interviewees, making more complex the need for and ability to ensure confidentiality, reliability of the data, and so forth. The researcher was highly aware of this special aspect of the research, and made sure to communicate to the participants the benefits not only for themselves (by offering post-research training in the new programme, should they wish to incorporate such elements into their own practices) but also for their clients—the ultimate research subjects of this thesis—in terms

of providing them with psychotherapeutic support and services better tailored to meet their needs.

## CHAPTER 2: INTRODUCTION

### ***2.1 Research Focus and Background***

This research focuses on the mental healthcare needs of Iranian couples that have emigrated to the UK, by evaluating a psychotherapy programme customised for this population. This population was chosen because of researcher's Iranian background and familiarity with Iranian culture, including attitudes, presumptions and popular perceptions Iranians hold about mental healthcare. Although the focus is the Iranian community in the UK, other cultural and ethnic, first and later generation immigrant groups may also require focused research. It is hoped that the results of the current research will provide the rationale for other scholars to embark on similar research with non-Iranian cultural and ethnic immigrants in the UK.

Given the growing Iranian diasporas in the UK, the paucity of research on the quality of mental healthcare for this population group is increasingly noticeable. The stress often experienced by people leaving their homeland to start a new life in another society, may exacerbate mental health difficulties. They may fear the new, unfamiliar culture, which for this population includes being exposed to a different religion. They may feel like strangers in their new society, and experience a loss of identity.

As of the 2001 Census, the UK was home to 40,767 Iranians. Estimates from the National Statistics Department of the UK had this number rising as high as 80,000 in 2011 (Smith 2008). A study by Shaghaghi, Bhopal, Sheikh, and Namdaran (2007) examined mental healthcare for Iranian immigrants in Western countries. These authors



reported that, at the time of writing, research on mental healthcare for this community in the UK appeared to be non-existent.

The lack of focus on understanding the mental healthcare needs and on evaluating the quality of services available to Iranians living in the UK, is cause for alarm. The total immigrant population in the UK is 12.4%—every eighth person living in the UK today was born abroad (Office of National Statistics UK 2013). According to a recent study by the University of Leeds, this proportion could rise to 20% by 2041 (BBC, 2010). These statistics imply that traditionally mono-cultural societies such as the UK have become increasingly culturally diverse. The nation's changing demographic profile raises several questions.

First, do current mental healthcare and psychotherapy services in the UK meet the needs of the UK's growing multi-cultural population? In the specific context of the current research, are these services suitable for the Iranian immigrant community in the UK? If so, there would not be a need to develop culturally sensitive psychotherapy models. However, several reports on the mental healthcare needs of the UK's culturally diverse population, as well as reports on the quality of services available, justify further critical consideration of the adequacy of current mental healthcare services. It has been argued that a culturally-sensitive psychology should be based upon social, developmental, health, personality and cross-cultural perspectives (Ward, Bochner & Furnham 2001). According to a paper produced as part of the King's Fund Mental Health Inquiry, Keating, Robertson and Kotecha (2003) stated that, '[i]n the past five years, race equality in mental health services has been prominent in policy developments at a

national level. However, at local levels, there is evidence that it is not accorded sufficient importance. New structures have emerged to provide greater opportunities for partnership and consultation with BME (Black and Minority Ethnic) communities. These include health action zones and local implementation teams. However, these initiatives are not always sustained. Acute care remains an area of concern for BME communities because of restrictive treatment regimes' (p. I).

Two facts revealed by this paper were of special significance to the current research. First, policy makers in the UK recognise that mental healthcare in diverse communities requires special attention. Second, systematic, concerted, policy-based governmental interventions were not as successful as anticipated. The non-sustainability of community-based healthcare programmes is acknowledged as a significant factor in the frequent premature termination of psychotherapy by those from different cultures. Most research on premature termination of therapy comes from previous US studies. The problem is usually dealt with at a macro-level, and focuses on socioeconomic background as the main factor influencing early termination.

The personalities of Western clients are embedded in Western culture. By contrast, Eastern clients are socialised into Eastern cultural beliefs and norms. Of course, to say this is overly simplistic, as subcultures within overarching cultures may ascribe to vastly different cultural values (Minkov & Hofstede 2012), because individuals differ extensively, within and between cultures, and because socialisation within cultures may take different forms. Nevertheless, there is substantial evidence of significant cultural distinctions between East and West, which may reasonably be anticipated to impact upon

how individuals from different cultures receive and respond to therapeutic intervention (Al-Thani 2010; Farsimadan 2011). How can a sustainable, effective difference be made in the way mental healthcare and psychotherapy are offered to culturally diverse clients? This question engenders others: For example, to develop culturally sensitive psychotherapy for culturally diverse clients, should we treat all non-Western clients as one group, and develop one programme for them? How meaningful is the concept of nationality and culture when it comes to examining an individual's intrapsychic world, and might this be a useful factor to maximise therapeutic success? Furthermore, how do issues pertaining to culture relate to the fact that these clients have emigrated and thus been separated from all they know and thrust into a country that differs, in some senses radically, from their own—are the issues more a question of the trauma of misplacement and loss of identity (not only cultural, but also ethnic, personal, social, economic and individual) than of a clash between cultures? It is the purpose of this thesis to investigate the existing literature on all such matters, and to examine the efficacy of a psychotherapeutic programme that takes seriously and puts into practice a cross-cultural approach.

In a world in which national mobility has become commonplace and in which economic and other factors often prompt emigration; more and more people uproot to resettle in a different country. The phenomenon of culture shock has been studied since the middle of the last century, and likely earlier. It has been described as 'the anxiety that results from losing all our familiar signs and symbols of social intercourse...the...ways in

which we orient ourselves to the situations of everyday life' (Oberg 1954 in Ward, Bochner & Furnham 2001, p. 1). The increasingly global mobility of modern society means there are a high proportion of travelers, immigrants, sojourners, refugees, expatriates, exchange students and contract workers in most countries of the world, rendering culture shock increasingly deserving of serious research attention (Christodoulidi & Lago 2010; Ward, Bochner & Furnham 2001).

An examination of what culture shock means must of necessity consider cultural differences, including different frameworks for individualism and collectivism in different cultures, as well as some of the consequences of previous contact amongst certain cultures; for example, genocide, assimilation, segregation and integration (Ward, Bochner & Furnham 2001). Details, such as fine points of cultural etiquette, paralinguistic factors and ways in which conflict is resolved in specific cultures, should be carefully examined in order properly to characterise the elements of culture that define a person's daily manner of functioning, and how this might be disrupted by being transplanted from one culture to another (Ward, Bochner & Furnham 2001). Such transplantation is often experienced as highly stressful, and individual characteristics such as personality, as well as societal factors such as social support networks, play a role in mediating this stress (Ward, Bochner & Furnham 2001; Farsimadan 2011).

Various reactions are seen to such cultural conflict, contact and transplantation, and these predictably in one of three directions: rejecting the new culture, rejecting the old culture and assimilate the new one, or integrate aspects of both into a new kind of personalised cultural identity (Jalali 1982; Ward, Bochner & Furnham 2001; Farsimadan

2011). Although culture shock is anticipated to occur in people of all races, cultures, nationalities and ethnicities, different groups may react differently and, importantly, may be amenable to different kinds of interventions; thus, students, business people and refugees, for example, might respond most successfully to stress reduction interventions tailored specifically to factors particular to their culture shock situation (Ward, Bochner & Furnham 2001). Culture training and an emphasis on bicultural competency have become features of modern society. Culture shock is increasingly characterised 'as an active process of dealing with change rather than as a noxious event' (Ward, Bochner & Furnham 2001, p. xiii). Affect, behaviour and cognition associated with culture shock may be discussed as topics in their own rights; though, inevitably, they are inextricable. Research on affect has centred on theories of coping strategies, stress and psychological adjustment; social identity theory has been widely used as a means of exploring cognition in culture shock (cognitions 'may result in the development and change of a specific identity, which has implications for self- and intergroup perceptions' (Ward, Bochner & Furnham 2001, p. xiii); behaviour is mediated by learning, and leads to new skills and sociocultural adaptation. Culture shock may be eased by the acquisition of new skills through programs such as behavioural training, mentoring and learning more about the history, society, politics and philosophy of the new culture, as well as therapeutic intervention to alleviate conflicting values and perceptions (Ward, Bochner & Furnham 2001). An interesting and important finding emerging from such research is that prejudicial attitudes towards the new culture may sometimes be beneficial or adaptive in some way for the person experiencing culture shock, which explains why such attitudes

are highly resistant to change and perhaps provide a means of understanding and working with such perceptions and beliefs (Ward, Bochner & Furnham 2001). This is consistent with psychodynamic theories on the utility of aggression as a protective defense.

This NHS has attempted to render mental healthcare services more sensitive for culturally-diverse clients. According to Fernando (2005), 'the umbrella term "black and minority ethnic (BME—for Asians, Chinese, Caribbean/African and Black African) communities" is used by the UK government, as well as the NHS, in directing research and development of psychotherapy programmes for a diverse population' (p. 9). Thus, the official stance on culturally sensitised psychotherapy is to develop therapy effective for all non-Westerners.

As a consequence, despite the numerous culturally diverse populations in the UK (Office of National Statistics, UK, 2013), little research has been undertaken in this regard.

### ***2.1.1 Does one size fit all?***

In a bid to explore these questions, the relevant literature was reviewed, with a particular focus on whether culturally diverse clients should be treated as a homogeneous group, or whether specific, culturally sensitised forms of psychotherapy should be developed for different cultures. The answer to this question is nuanced. In much of the work on existing culturally-sensitised models of psychotherapy, a strong historical, geopolitical, religious, and cultural understanding of individual clients is encouraged; i.e. clients were expected to have unique historical-geopolitical-religious orientations, which

would guide their perceptions, attitudes, behaviours, needs and expectations of therapy. This is consistent with recent findings by Al-Thani (2010; Al-Thani & Moore, 2011). The notion of targeting each cultural community with a particular psychotherapy programme, employing the worldview of the community and therefore delivering contextually relevant psychotherapy, was supported. The underlying focus of the current research was to develop a customised psychotherapy programme for Iranian couples, both hetero- and homosexual.

In the Iranian culture, same-sex marriage is prohibited, and, although legal in the UK, is still culturally condemned in the Iranian community living in the UK. Thus, most homosexual couples seek psychotherapy only reluctantly; afraid their community may judge them. The identity of gay and lesbian couples at FPEP, for example, was not disclosed to other seminar members. They had faced stigma, even in their current Western environment, in the UK or in Germany. The topic of homosexual relationships was raised during the seminar by the researcher, and a dialogue on the matter was encouraged and facilitated, allowing attendees to discuss the social, psychological and cultural issues affecting the lives of many homosexual individuals from Iran.

Another issue discussed was what exactly should be the focus of effective, culturally sensitised psychotherapy and how this may most effectively be researched.

A preliminary review of the literature confirmed that there is a gap in the research regarding culturally nuanced psychotherapy. Research findings and theoretical ideas on the topic of culturally sensitised psychotherapy, proposed by academics and practitioners, propose psychotherapy models ranging from slightly modified Western ways of working,

such as Cognitive-Behavioural Therapy (CBT) or Person-Focused Therapy (PFT), to innovative therapies not dissimilar to those used by shamans or witch doctors. The field of cultural psychotherapy is vibrant, but there is a lack of focus on developing standardised programmes for specific cultural groups.





## **CHAPTER 3: LITERATURE REVIEW**

In this section, the literature review is presented. It includes empirical research as well as theoretical ideas relevant to the current topic.

### ***3.1. Introduction***

There is an ongoing debate amongst therapists and scholars surrounding the need for culturally responsive or culturally competent psychotherapy. Herman et al. (2004) argued for the need for innovation in the field of psychotherapy, whereby innovation is approached as 'an important voice and unique perspective to the national dialogue about promoting emotional wellness' (p. 764). A national approach to psychotherapy should include specific cultural considerations with regard to psychotherapy.

Culturally competent psychotherapy is desirable; without it, cultural differences between clients and therapists may lead to bias, stereotyping, and reduced therapeutic efficacy (Schulman et al. 1999). The question arises whether culturally competent psychotherapy is desirable at a governmental level, or whether it perhaps is desirable for purely political reasons. Is it merely a way to window dress the healthcare system as multi-cultural? Despite the fact that political factors play a role, especially in countries such as the UK that are now extensively multi-cultural, the more critical aspiration is for psychotherapy to be meaningful, balanced, unbiased and engaging for ethnic communities. This has driven most of the research concerning the development of culturally competent mental healthcare. Scholars such as Bernal and Scharrón-del-Río

(2001) as well as Smedley et al. (2003) have extensively reviewed evidence-based psychotherapeutic treatments, showing them to be incompetent in treating clients from diverse ethnicities.

Previous work in the US has shown that, compared to white Americans, ethnic minority groups under-utilise or prematurely terminate treatment (Pole et al. 2008; Sue 1998). Furthermore, racial and ethnic minorities tend to receive lower quality healthcare as compared to non-minorities. They have less overall access to care and are not as likely to receive effective, state-of-the-art treatments (U.S. Surgeon General 2001). These disparities are considered the result of inadequacies in service rather than access-related factors (e.g., medical insurance) or a need for different services (Smedley et al. 2003). According to another study disparities in healthcare delivery have developed from speculation to a confirmed phenomenon, which prevails in the treatment of ethnic minorities in the US (Antaki, Barnes & Leudar 2004).

Mention of the historical relationship between therapy and ethnicity would be incomplete without a discussion of ethnic identity development. The first psychological theories on ethnic identity development may in hindsight more accurately be understood as theories on racial identity development, and were based mainly upon the psychological responses of African American's to oppression (the Cross Model; Cross, 1971, 1980 in Smith 1991). Although this model failed to consider ethnicity more generally, it should still be credited with making a significant contribution to research and theory: it emphasised that a person's ethnicity is an integral part of the way they develop their personality and identity (Smith 1991); indeed, their entire intrapsychic apparatus. Today, this field is constantly evolving, and there has been a proliferation of conceptualisation, theoretical development and instruments designed and validated to measure concepts such as black racial identity and consciousness, white racial identity, and multiracial and

ethnic identity more accurately (Ponterotto & Park-Taylor 2007). The types of issues ethnicity involves, and which are central to the current study in terms of Iranian culture, include family structure, the roles of men and women in the family, belief systems and values imparted by parents and the society or community, language, ethnic signage and symbology, as well as certain perspectives—it is thus clear that, although ethnicity may include race, it is not limited to this factor (Smith 1991).

Fitzpatrick and Chamodraka (2007) propose culture-based psychotherapy as a solution to the bias in healthcare delivery, reasoning that culture-based psychotherapy transforms the primary ideology from policy-centred to client-centred: services are tailored to meet the cultural needs of a particular group, instead of treating individuals as single entities. This approach makes it more difficult to justify discrimination against others by invoking service inadequacies (Fitzpatrick & Chamodraka 2007).

The ethical debate about current service delivery bias for ethnic minority groups in the US continues. An interesting argument is that most ethnic minorities do not appear to have the positive outcomes common in most forms of health intervention (Hutchby & Wooffitt 1998). According to this argument, the problem is not with the system but with the subjects receiving the healthcare. In the opinion of Antaki et al. (2004), psychotherapy has been often cited as one of the healthcare delivery areas that produce ineffective outcomes in ethnic minorities. There is consensus in the US that ethnic minorities are unable to receive or benefit from psychotherapy in the same way as mainstream Western populations (Antaki et al 2004). A large amount of the data in this context is from the Institute of Medicine, USA (1999) and from the U.S. Department of Health and Human Services (2001).

The most influential theories thus far in the fields of ethnic and racial identity include the model of psychological nigrescence (Cross, 1971, 1991), the White identity model (Helm 1984, 1995) and ethnic identity development (Phinney, 1989, 1990).

Cross's work was the foundation for at least 22 theories of racial, biracial, multiracial, gay and lesbian, ethnic and feminist development. How well, comprehensively, coherently and clearly are these constructs defined by these and by subsequent theories—how well has the field done so far in creating accurate, reliable, valid, representative constructs of these real-life phenomena; is research using these concepts in fact gathering the information it purports to?

Key researchers in this field agree that the challenge in developing an integrating such theories is that they 'have operated from different generations of race, ethnicity, racial identity, and ethnic identity' (Ponterotto & Park-Taylor 2007, p. 283). '[T]he inconsistent and interchangeable use of ethnicity and race and ethnic and racial identity prohibits researchers from identifying psychological mechanisms that differentiate and distinguish the constructs from each other, which ultimately raises more questions than provides answers in the study of ethnic and racial identity' (Cokley, 2007; p. 283). As a result of this lack of integration, multicultural counseling and therapy is in a similar state of disarray and fragmentation—the lack of construct clarity leads to hindered theory development, limitations in empirical studies and, ultimately, unfocused treatment, with no standardised means to assess outcome.

Racial and ethnic identity have historically been studied in the context of culture, across various scientific and intellectual disciplines, and this should be taken into account when attempting to further and integrate such theories; they can neither be examined nor developed in isolation—and, most importantly, to help clients with integrating their own various identities, in order to live a more coherent psychic life (Ponterotto & Park-Taylor 2007). Counseling psychology has long proclaimed close connections with developmental and social psychology, as well as with cognitive, community and positive psychology; however, it is argued here that it should also work in close concert with biology, anthropology, sociology, history and the study of spirituality (Ponterotto & Park-Taylor 2007). This variety of traditions, perspectives and practices is hypothesised to be the best way to achieve best practice in medical care—the most comprehensive

conceptualisation and treatment of concepts and related difficulties/disorders possible (Ponterotto & Park-Taylor 2007).

The following conclusions are summarised in this article with regard to the scientific understanding of ethnic and racial identity development: racial and ethnic identity development involves exploration and crisis (occurring normally during adolescence and then in the context of sociopolitical stress - e.g., the experience of racism may trigger such exploration); benefits of positive identification with one's ethnic group (appears to act as a buffer against other, nonracial forms of stress); being prepared for discrimination may lead to healthier personal adjustment; sequencing of racial and ethnic stages and statuses (Ponterotto & Park-Taylor 2007).

Examples of best practices in scale development and revision: the Cross Racial Identity Scale (CRIS; Cross & Vandiver, 2001); the White Racial Consciousness Development Scale-Revised (WRCDS-R; Lee et al., 2007); the Ethnic Identity Scale (EIS; Umaña-Taylor et al., 2004); the Multigroup Ethnic Identity Measure-Revised (MEIM-R; Phinney & Ong, 2007). All are presented here as excellent examples of new or revised measures of these constructs and exemplars upon which future research should be based (Ponterotto & Park-Taylor 2007). Recommendations include that all future research should take care to define constructs carefully and clearly; the rationale for choosing a specific scale should be consistent with the theoretical background of the study; reliability generalisability should be conducted in all studies of ethnic and racial identity development, to determine whether sampling and testing conditions affect reliability, amongst other suggestions (Ponterotto & Park-Taylor 2007).

In terms of practice and supervision, it is 'essential for counselors who are confronted with their client's identity and the problems it creates for them particularly when they are of mixed ethnic heritage. Working through a client's identity problems

requires that the counselor understand the constructs' origins and how clients frame their problems and puzzlement' (Trimble, 1996 in Ponterotto & Park-Taylor, 2007, p. 290).

Carter (1948) conducted seminal work on racial identity development and its impact on therapeutic outcome, arguing that race is fundamental to the history and fabric of North American society, but that psychology, psychiatry and all related mental health disciplines nevertheless fail to afford it proper prominence in human development and the development of identity. Attending this is a failure to acknowledge its potentially important place in treating mental disorder. The recognition of ethnic as separate from racial identity theory may be conceptualised as somewhat of a revolution within the psychological scientific community (Ponterotto & Park-Taylor 2007). Traditionally, psychotherapeutic approaches have taken race into account as a factor affecting mental health only when 'a person of color brings it into treatment...in White/White dyads, race is typically thought not to matter or to exist as an aspect of mental health' (Carter 1948, p. 1). When a non-White client, for example, a Black or Hispanic client, raises race as an issue with their White therapist during psychotherapy, it might be interpreted as a defense or avoidance mechanism, as a way of not dealing with the significant intrapsychic material at hand. Carter argues for race to be regarded more as a personality and treatment factor, in order that its impact on human development and the psychic experience of the individual may be understood. Social science research observes that race is employed as a legally sanctioned social category for the purposes of dividing resources according to public policy, and mention has been made of the role psychologists and psychiatrists need to fill in order better to characterise the role of race and its use within the mental health disciplines (Yee et al., 1993 in Carter 1948) and, it may be argued, within society as a whole.

Race affects the development of a person in complex ways; thus it is reasonable to expect that it might affect the therapeutic process with similar complexity. He notes that the complexity of the effects of race are bound up with socioeconomic, historical, intrapsychic, sociopolitical and contemporary happenings, and that this makes the topic

remarkably difficult to define and contain (Carter 1948). He argues that race impacts on client referral in therapy, as well as descriptions, conceptualisations, patient-therapist dynamics, but that clinicians and researchers today appear more comfortable with cultural and ethnic issues than with racial ones, and, furthermore, that race is sometimes subsumed not only under umbrella definitions of culture, which completely fails to take account of its unique contribution to individuals and their psychic makeup. He suggests that individuals identify to varying degrees with their racial groups. 'Moreover, racial identity theories posit that a person's resolution is psychological and it seems to guide that person's feelings, thoughts, perceptions, and level of investment in his or her racial group's cultural patterns' (Carter 1948, p. 4).

Carter recognises that transference and countertransference may partially account for how race influences the therapeutic relationship, but adds that a person's racial identity (how closely and in which ways they identify with their racial group) is integral to personality and human development, and thus to therapy, too (Carter 1948). Race has powerful historical, emotional and psychological connotations, because it is considered to be innate, although this has been contested and debated. It is in this way that it presents a different kind of variable than do ethnicity and culture, which are considered more secondary and social than race (Carter 1948).

Both the client's and the therapist's racial identity may affect the therapeutic process, and the interaction between racial identity and other elements of psychological functioning are important (Grace 1948). Racial identity is based on a complex interaction of how others appraise one, and how one appraises others. When developing racial identity, evaluations of oneself are based upon others evaluations of oneself, especially and primarily how one's parental objects evaluate one; the reverse is also true, one evaluates others based upon how one evaluates oneself. Racial identity profiles will likely influence how a client relates to others, is productive, tests reality and manages his affect. For example, a Jewish client who is raised in an environment in which there is significant anti-Semitic sentiment can lead to a problematic, fragmented racial identity profile,



which might lead the client to attempt to reconcile this feeling of fragmentation by merging with idealised others (in terms of race or some perceived notion of being admired, etc.). In such a case, identification of the client with a Black therapist might represent a 'darkening' of the client and further attempts to obliterate that part of herself, which might be more destructive than being in therapy with someone with whom such a client might have a strongly idealised transference (Grace 1948).

Macran et al. (1999) advise that 'for evidence, political and conceptual reasons it is important for psychotherapy researchers to consider clients' perspectives' (p. 325). This suggests that psychotherapists should consider the fact that clients have a specific set of beliefs and values that may influence their participation in psychotherapy. The next step for psychotherapists is to ensure that clients are able to express their own beliefs and values. Moreover, they must be able to work with an understanding of the client's perspectives in mind (Macran et al. 1999). This is particularly true in situations when client and psychotherapist have a different cultural background (Mandelbaum 2013). It is essential for the psychotherapist to consider whether a client's behaviour reflects his particular culture or whether it conforms to his cultural upbringing (Martin 2009). An understanding of the client's culture, race, ethnicity and nationality, as well as of their personal identity and how these are bound up with one another, and consequently of the acceptable norms and values to which he subscribes is needed before a psychotherapist can offer an accurate diagnosis and provide effective treatment.

There is a lack of clarity about how commonly held this view is amongst healthcare professionals. The question is whether healthcare professionals are equipped to deal with culturally diverse clients after a degree of adequate training. For instance, research by Lopez and Hernandez (1986) found that 83% of an overall sample of 118 clinical psychologists reported the significance of considering a client's cultural background in making a diagnosis and recommending a course of treatment. Similarly, in a survey of 136 mental healthcare providers, the issue of cultural difference was perceived as important when thinking about their Hispanic clients. The same study

reported that 69% of the healthcare professionals felt the need for more culturally focused training (Lopez & Hernandez 1986). In a similar study of 170 mental healthcare providers, all respondents reported believing in the significance of cultural issues in therapy. However, a lack of such cultural sensitivity was perceived in their own training (Ramirez et al. 1996). 23% of these respondents reported not having received any culture-based training.

A parallel may be drawn between the United States and the UK in terms of the growing cultural and ethnic diversity of the two nations, leading to an increased need to address difficulties associated with immigrant populations of various cultures. Cultural diversity is attributable to the increasing social and political sets of cultural expectations, beliefs and values in the healthcare, business, and political and educational systems, owing to the physical presence of these groups. It is associated with the presence of various cultures in one region. The current research is informed by studies that focus on mental health interventions for ethnic minorities in the US.

According to Miller et al. (2013), impressive outcomes continue to be obtained from psychotherapy as practised by 137,000 licensed members belonging to the American Psychological Association (APA). New interventions have been put into practice for addressing the specific cases of ethnic minorities. There is an ongoing debate among US policy makers regarding the use of Evidence-Based Treatments (EBT) in their original form, or following their modification to render them culturally congruent. Another possibility is whether it is advisable to develop completely new EBTs for each culturally diverse groups.

Ferrara and Bell (2005) note that there is a strong argument for the fact that in most multi-cultural societies, such as the UK, Australia, and the US, most forms of health

variables, e.g., causes of deaths, mortality rates, access to health infrastructure, and trend of diseases are often determined along ethnic and cultural demographic lines. So far, having a centralised approach to health that attempts to serve as a universal healthcare model for everyone cannot be guaranteed to be effective in addressing everyone's healthcare needs (Barkham & Shapiro 2006).

Based on this, the best approach for a healthcare model when considering culturally diverse communities has been identified as the decentralised approach to healthcare delivery, of which culture-based psychotherapy is considered a key component (Fitzpatrick & Chamodraka 2007). Hutchby and Wooffitt (1998) argue that by applying a decentralised approach to healthcare delivery, the aim of service providers is to provide local people with the opportunity for regulating their own healthcare system. In this way, local populations become more capable of emphasising their healthcare needs, taking into account the different demands in different locales.

Thus, when justifying the need for psychotherapy, as a first step might be an assurance that the therapy will be decentralised or culture-based (Ferrara & Bell, 2005). There is a need to explore culture-based therapies and to provide better training to psychotherapists about how to treat culturally diverse clients.

### ***3.2 Is There a Need for a Culture-based Psychotherapy in the UK?***

The UK is multi-cultural in nature. Recent estimates are that one in 35 people worldwide is an international migrant (Koser 2007 in Christodoulidi & Lago 2010), and these numbers have likely increased exponentially since then. There is little research on

the efficacy of multi-cultural therapy currently available for diverse communities living in the UK, particularly for those from the Middle East. The studies that have been done are based on the assumption that the needs of all diverse groups may be grouped as a single entity. For instance, Fernando (2005) elaborates that the umbrella term 'black and minority ethnic (BME—for Asians, Chinese, Caribbean/African and Black African) communities' is used by the UK government, as well as the NHS, in directing the research and development of psychotherapy programmes for diverse populations. More specific culture-based therapy programmes, to address the specific needs of individual communities, have not been developed.

Using the experience of the United States as discussed earlier, there has been a considerable number of studies demonstrating that ethnic minorities tend to be apathetic about psychotherapy. Markova and Foppa (2011) call for the current UK system of classification to be reconceptualised since, in the United States, researchers could not probe further to explain factors underlying the absence of positive outcomes in ethnic minorities undergoing psychotherapy. Barkham and Shapiro (2006) speculate that psychotherapies may be structured in ways that benefit the white-dominated population of the US rather than ethnic minorities - which the issue is not with the people receiving the psychotherapy, but with the suitability of the type of psychotherapy itself.

There is therefore a call for further classification among minority groups in the UK rather than merely grouping them all under the term BME (Barnes & Moss 2007). Markova and Foppa (2011) argue for a more specific classification: if failure of psychotherapeutic intervention is assumed to be related to its inappropriateness for ethnic

minorities, then developing interventions specific to each minority group would not solve the problem.

There are few studies evaluating the available mental healthcare programmes in the Middle Eastern—specifically the Iranian—UK immigrant population. Only one study was found, conducted by Shaghaghi et al. (2007), which dealt specifically with the subject of mental healthcare for UK Iranian immigrants. It critically appraised 13 previous studies (of 30 potential cases) to evaluate the existence of healthcare research in the UK Iranian community. It is perhaps the most comprehensive and possibly even the only piece of research that has endeavoured to ascertain the magnitude and quality of research into mental healthcare in this community. Shaghaghi et al. (2007) established that research on culture-based psychotherapy for the Iranian community is scarce. This study located published data on healthcare policies established for Iranian migrants in the UK. The significance of this research lies in the fact that it reviewed both qualitative and quantitative articles. It noted that evidence on which healthcare for the Iranian diasporas is based, is limited. It commented on ways in which methodology might be improved upon, in order to produce better evidence-based research in this area. It did not, however, investigate the manner how policies for meeting the vastly culturally diverse needs of Iranian immigrants may be improved. The current study aims to fill this gap in the literature (Shaghaghi et al. 2007).

Drew (1991) argued that the absence of sufficient primary research to justify the efficacy of culture-based psychotherapy in different communities in the UK would continue to hinder the successful implementation of culture-based psychotherapy. It is

associated with the fact that service providers are expected to support their clinical interventions with evidence-based review as part of best practice in the healthcare sector. This is considered an assurance that an intervention has the potential to bring about significant improvement (Corsini 2005). This claim could be considered an authoritative justification for a mental healthcare approach starting with a comprehensive classification system. Relevant research has shown it to be beneficial in identifying the unique trend of response among people of different cultural settings (e.g., Shaghaghi, Bhopal, Sheikh & Namdaran 2007).

This recommendation has also been based on the outcome of the study by Barnes and Moss (2007). These researchers argued culture-based psychotherapy necessitates careful consideration. It is interrelated with the reactions, perceptions, attitudes and adaptability of the recipients with regard to the intervention. It suggests that, unlike the use of medical interventions, which may work in exactly the same way for all individuals, culture-based psychotherapy might work differently according to the socio-cultural variables of the people receiving the intervention. Based on these conclusions, there is a need to increase culture-based research in the UK.

Another noteworthy study aimed to ascertain the impact of an intervention for enhancing cultural competence among healthcare staff (Papadopoulos, Tilki & Lees 2004). This study highlighted the significance of nature for healthcare staff, as they are required to express empathy towards culturally diverse clients.

### ***3.3 Scope of Cultural Therapy***

According to Smith, Richards, Granley and Obiakor (2004), all approaches to psychotherapy are culturally biased, as the traditionally available Western psychotherapeutic approaches are informed by Western culture. This contention of Smith et al. (2004) is justified; Western methodologies are indeed guided by an understanding of human needs, psychology, and consequent treatments based on a US and/or European perspective. There would be no need to consider therapy in terms of cultural relevance if one homogenous culture existed and if psychotherapists dealt exclusively with European or American clients. However, with the changing demographics of countries like the UK, and with an increasing number of diverse cultural and ethnic groups seeking psychotherapy, the problem of culturally relevant psychotherapy has come to the fore.

A plethora of additional questions arise following recognition of the need for culturally relevant psychotherapy. The foremost question is, what constitutes culturally meaningful or relevant psychotherapy; that is, what are the factors that would make psychotherapy meaningful for culturally diverse people?

Prior to exploring this question, as is the focus of the present study, it is pertinent to consider in which psychotherapeutic situations culture becomes relevant and explicit? Is it when a Western psychotherapist encounters clients from backgrounds that are dissimilar to his or her own culture? Or does the need for cultural relevance arise even when the psychotherapist and client belong to the same socio-cultural background?

In the first instance, in cases where the psychotherapist and client differ in their cultural backgrounds, the issue encountered can be a complete or partial lack of

understanding about the other's culture, which may lead to a lack of accurate communication between psychotherapist and client. The psychotherapist may be culturally grounded in a Western world-view and might overlook the different cultural learnings of the client (Macran et al. 2004).

One of the most pervasive reasons for the tendency for psychotherapy researchers to neglect clients' perspectives stems from the relative domination within psychotherapy research of what has been termed the "drug metaphor" (Macran et al. 2004, p. 326).

On the other hand, the client might feel intimidated due to his prejudices or stereotypical perceptions of Western psychotherapists (Smedley et al. 2003). In the literature on cultural psychotherapy, the view that the scenario involving a Western therapist and a non-Western client necessitates a culturally-based psychotherapeutic approach is dominant. The same may be said of other similarities between client and therapist, such as sexual orientation (Zur Institute, 2013). This presumption underpins most work on the development of cultural psychotherapy programmes. These frameworks are restricted in making recommendations to therapists about taking account of their clients' cultural perspectives. Ultimately, the therapist is responsible for gaining an understanding of the client's emotional issues, stress and intrapsychic conflicts. This will include factors not only of individual personality, current environment, history, context, resources, aims and goals, but also of racial identity (Carter 1948; Grace 1948) — which may constitute a central issue for clients, especially if they live in race-



conscious societies, and may affect how someone assesses themselves and others—ethnic identity (Farsimadan, Draghi-Lorenz & Ellis, 2007), sexual orientation as mentioned above, gender, and so on.

In the second case, the problem might not lie in cultural differences between psychotherapist and the client, but rather in the difference between their education and upbringing (Macran et al. 2004). It is possible that a psychotherapist, educated and proficient in Western methodologies, may have her outlook towards world moderated by Western education even though her background or culture is non-Western. The psychotherapist may be inclined, as a consequence of her training, to overlook the client's cultural inhibitions (Eagle, Benn, Fletcher & Sibisi 2013). This situation is not addressed by the majority of research studies in this field, indicating a gap in the research. This gap is probably significant, as there is an increasing number of non-Western psychotherapists in the UK trained in Western methodologies (Hwang 2011; Lee 2012).

In either scenario, the case for the cultural relevance of psychotherapy applies. The Western psychotherapist needs to accept the role played by the client's view towards the world as an essential factor in the efficacy of the psychotherapy (Kanter, Santiago-Rivera, Rusch, Busch & West 2010). Similarly, a psychotherapist who is Western educated and culturally compatible with a client should be mindful of how the Western methodologies and treatments she adopts might suit the sensitivities of diverse clients (Kanter et al. 2010; Larson & Corrigan 2010). Larson and Corrigan (2010) note the

dialogues of a psychotherapist presenting counselling after understanding the cultural and personal aspects of the client:

Let me check to see if I'm following. You are feeling fear about people finding out about your secret and this may hurt your business and friendships. You felt anxiety and fear when discussing mental illness with your friends. You felt guilt, disgust, and anger when you heard your friend's comments about mental illness (p. 529).

Another possibility is the case in which psychotherapist and client both belong to non-Western cultures, but different ones. For instance, an Indian psychotherapist might work with a Latin American client. The situation may become even more complex: not only is the psychotherapist trained in Western methodologies, the perspective of the therapist might deviate entirely from that of the client (Kim, Zane & Blozis 2012). Kim, Zane and Blozis (2012) state:

Proximal variables in this case may include those that are related to one's race/ethnicity, such as immigration history and socioeconomic status. Given that such variables remain rather immutable characteristics of an individual, more informative proximal variables may be those clinical characteristics of clients that therapists are able to identify and target within sessions to enhance the effectiveness of treatment (p. 1288).

Education and culture may both represent barriers to the dynamic interaction between client and psychotherapist, thus undermining the efficacy of psychotherapy.

Research related to such case scenarios was not found during the literature review. Hence, it may be presumed that most cultural therapy research is of the situation in which a Western psychotherapist, educated in Western methodologies is present, while the client is from a different cultural background. The next section reviews the literature on how cultural therapy programmes are composed, and on guidelines for delivering effective psychotherapy to diverse clients using these programmes. It is based on the assumption of the aforementioned psychotherapist-client pairing.

Culture-based therapy should ideally be applied in any situation in which the ethnically and culturally different client is involved in psychotherapy in the context of Western framework and methodology, regardless of the ethnicity or cultural orientation of the therapist. This nevertheless does not mean that the ethnic or cultural orientation of the therapist should be disregarded; on the contrary, it should be included in the development of cultural therapy programmes. Openness is required in all psychotherapy, regardless of the therapist's background.

We may conclude this section by stating that the scope of culture-based therapy is highly dependent on the cultural background of the client and the contextual setting and education of the therapist, rather than merely emphasising the cultural backgrounds of client and therapist. According to Corsini (2005), 'Psychotherapy is a formal process of interaction between two parties, each party usually consisting of one person but with the possibility that there may be two or more people in each party, for the purpose of amelioration of distress' (p. 1 ). It is associated with the fact, as noted by Corsini (2005) that therapists base their culture-based therapeutic interventions more on the context of

their education rather than on the basis of their background. In this way, a therapist with a Western background may specialise in African culture-based therapy and deliver outcome-oriented therapy to Africans from an African context. At the same time, the opposite may occur with an African therapist. There needs to be sufficient orientation so that clients can accept the scope of culture-based therapy based on the contextual and educational setting of the therapist, rather than on the therapist's cultural background (Coupland 2003).

More research is required to justify if people from Western backgrounds do better receiving therapeutic training and education from Western contextual settings as compared to other cultural settings. There is a notion among some clients that a therapist from their own background might better deliver culture-based therapy to them, unlike a therapist from a different setting with the same training (Corsini 2005).

### ***3.4 Models of Psychotherapy***

The utility, scope, and need for culture-based psychotherapy have been the topic of intense debate over the past decade (Pistole 2004). Opinions differ vastly as to the necessity of culture-based psychotherapy. Some scholars argue that Western psychotherapy is sufficient for clients from any background. Others argue for culture-based psychotherapy, believing that the therapists need to have appropriate cultural awareness, knowledge and skill to work with clients. The most complex debate is about what should constitute culture-based psychotherapy: which elements should be modified or adapted to render traditional therapies culturally relevant? A wide range of activities

dealing with language, the discussion of cultural issues, and the delivery of treatment in a cultural consistent manner, need to be addressed.

Among the scholars promoting cultural competence as an inherent requirement for psychotherapy, there are different views on the content, treatment, and approach to psychotherapy deemed culturally apt for diverse clients. These different approaches must be sensitive to the differences between cultures. Focus is placed on the therapist's expertise in culture specification and more specifically on the therapist's flexibility and personal skills in working dynamically. The models of culture-based psychotherapy should be integrated with factors such as individual differences between client and therapist, and the nature of the intervention, including factors that might determine treatment outcome in multi-cultural clients. Some models have been developed to identify cultural gaps in particular treatments and/or to accept adaptations that address these gaps (Leong & Lee 2006).

Following is a discussion of the available literature, leading to the development of a broad framework of culture-based psychotherapy based largely on theoretical frameworks proposed by other scholars. This framework forms the final section of this chapter. The framework is then modified based on the empirical research in this thesis.

### ***3.5 Western Psychotherapy versus Culture-Based Psychotherapy***

Some scholars argue for the preservation of traditional Western therapeutic approaches. For instance, Chambless and Ollendick (2001) maintain that traditional evidence-based treatments can be useful for all clients, with minimal alteration. However,

there are difficulties associated with such an approach that negate the impact of cultural differences in psychotherapy. Some of these problems are discussed in the section below.

### ***3.6 Western Psychotherapy and Assumptions about the Client's Perspective***

Predominantly, the problem with traditional psychotherapeutic approaches lies in the fact that the traditional methods of Western psychotherapy are rooted in the work of classical theorists such as Freud, Jung and Wolpe. These theoretical underpinnings have a profound impact on the attitude of therapists towards clients, but also on their psychotherapeutic approach. One prominent theme that has emerged related to Western educated psychotherapists' understanding of the psychotherapeutic process, is that the client's perspective may not be seen as central or even relevant (Stiles & Shapiro 1989; Zeig & Gilligan 2013):

A crucial assumption in the clinical trial of a drug is that the investigation is manipulating or at least measuring the biologically active ingredients. Therapists and clients emit an enormous variety of verbal and nonverbal behaviours within psychotherapy sessions, and researchers have no assurance that those aspects not measured in a given study are inert, analogous to fillers and flavours (Stiles & Shapiro 1989, p. 529).

There is a common assumption that the clients are passive recipients of psychotherapy and that psychotherapy requires deep exploration of the clients' thoughts and perceptions. This is an assumption fuelled by the image of a human being as proposed by the classical theorists.

For instance, according to Freud, most human problems are the result of unconscious processes about which the person is consciously unaware (Freud & Strachey 1962; Ferenczi 2012). This implies that the person may not have the competence or insight to understand what needs to be done and how it needs to be done to remedy his condition, and implies that the psychotherapist is the person who has insight into the process, even though the client may be unaware of the processes and problems caused by their own mind. With such a view of the client, it is probable that many Western educated psychotherapists might tend to treat the clients as passive vessels requiring psychotherapy, not unlike a medicine, to treat their illness (Macran, Hardy & Shapiro 1999; Zeig & Gilligan 2013).

Behavioural theorists tend to negate the thoughts and feelings of clients, overemphasising external behavioural manifestations (Wolpe 1958; Duncan, Miller, Wampold & Hubble, 2010). This approach leads to ignorance of client perspectives on the psychotherapeutic process (Macran, Hardy & Shapiro 1999; Norcross & Wampold 2011). The behavioural model of human mental function, let alone of the therapeutic process, is clearly flawed. To propose an explanation of behaviour based purely upon reflex-like responses to incoming stimuli is to discount the entire thinking, feeling, contextualised human being. Clients' thoughts about the therapy process are important; just as are the therapist's; furthermore, the *misperceptions* of both parties are fundamental to what transpires in therapy, just as misperceptions between any two interacting people are significant and exert a considerable effect on how those people relate. This is a highly salient point about transference and countertransference in psychotherapy, and speaks to how modes of relating in therapy can provide an excellent model for relating to the world. Psychotherapists prove just as inaccurate, if not more so, than others in their metaperceptions (what they think others think of them), and this is true regardless of culture and whether or not the therapeutic dyad is matched: therapists tend to think that

others, including clients, see them as more neurotic and as less conscientious, agreeable and supportive than others in fact do (Michels 2000). Similar to the neurotic countertransference, then, it would seem useful for psychotherapists to become aware of any differences in how people (especially clients) perceive them and how they *think* those people perceive them, 'such that these misperceptions do not cause miscommunications and ruptures in the therapeutic relationship' (Cooper, 2009, p. 95).

It may be argued that the underpinning of Western psychotherapeutic methods by classical theories leads to an implicit assumption that the client's perspective might not be accurate for ensuring effective psychotherapy. By contrast, Jefferson (2010) argued that the client's perception of psychotherapy is highly important and relevant to ensure effective psychotherapy. The basis of this argument did not specifically refer to psychotherapeutic methods or to the cultural background of therapists. However, an argument can be made that if the outcome of psychotherapy may be influenced by a client's perspective, then it is important to give maximum consideration to the psychotherapeutic methods used, emphasising the client's interest. This is supported by work on ethnic matching, which demonstrates that ethnically-matched dyads sometimes lead to better therapeutic outcomes (Farsimadan, Draghi-Lorenz & Ellis 2007). It should be remembered, however, that clients participating in such studies had specified a preference for such matching, and this may well have biased the results.

The qualitative nature of culture-based psychotherapy is further discussed below, including its dependence on socio-cultural variables, such as the attitude of clients to therapy. Luborsky et al. (2002) caution that, unlike medication, which, following administration into the body, functions based on the response of bodily systems,



psychotherapy deals with the mental attitudes of the client, which determine their response to psychotherapy. Thus, the notion that the client has no control over his mind during psychotherapy has been adequately challenged (Jefferson 2010).

### ***3.7 Western-Trained Therapists' Expectations with Culturally-diverse Clients***

One essential problem associated with lack of a culturally based psychotherapy involves the inherent clash between the expectations, presumptions, and perceptions of therapist and client. The differences between the expectations and perceptions of Western trained psychotherapists and those of culturally diverse clients, when dealing with psychotherapy, have been studied by Bachelor (2011). In a study of clients belonging to the general population and their Western-educated therapists, Bachelor (2011) found a substantial difference between the perceptions of clients and therapists of factors leading to a successful therapeutic alliance and to positive outcomes, even when therapist and client are from the same cultural background. There may therefore be underlying misconceptions about the client's motivations when participating in psychotherapy. Several other scholars have highlighted that this difference in expectations may be magnified when client and therapist are from different cultural backgrounds, which may have a debilitating impact of the efficacy of the therapy (MacMartin 2008).

A possible rationale for this difference in expectations could be related to the fact that traditionally Western-trained psychotherapists operate according to the premise that mental health is like any other illness, and believe that patients and their relatives will persevere with any intervention made for their benefit, and will support them (Maynard

2011). Many psychotherapists, counsellors or counselling psychologists hold this view. This underlying assumption contrasts sharply with the ground reality, which often involves a lack of belief in psychotherapy by non-Western clients, who may feel the same about any form of mental health intervention. Their perception of stigma, associated with the 'mentally ill', might inhibit them from engaging with the psychotherapist (Muntigl & Zabala 2008).

However, it should be noted that Western perspectives on mental illness are hardly united. Historically, attempts to define mental illness has been fraught with controversy. Foucault, the French philosopher and natural scientist, published a seminal text on this topic in 1961, in which he proposed that mental illness is better understood as a reflection of cultural context than as the expression of a medical condition (Beaulieu & Fillion 2008). The variety of views and criticisms of his thesis in themselves provide a neat representation of the disparity amongst different Western views—these ranged from outright pessimism and outrage, to modest consideration to adamant praise (Beaulieu & Fillion 2008).

In their review of his work and its impact on the conceptualisation of mental disorder, Beaulieu and Fillion (2008) relate Foucault's notion of 'the development of knowledge/power practices by studying disciplinary and normalization strategies. These analyses go beyond the framework of the psychiatric field, extending to all control mechanisms' (p. 75). These ideas were, nevertheless, focused on the psychiatric field in particular, and were developed throughout the following decades, becoming a point of reference for the French anti-psychiatry movement and were the basis for certain social health care strategies being reconceptualised. It remains an important reference and source today, with which weight is lent to movements that criticise and aim to change practices in psychiatry that conceptualise those with mental illness as "sick" with a disorder that is completely unrelated to society and should be treated as a dangerous and infectious agent within it, and contained accordingly. Importantly, this work speaks to the

fact that there have psychiatric movements throughout the West have been in disagreement since this time, and likely long before. It is by no means a question of strictly Eastern versus Western notions of mental health that is at question here; merely a recognition of the fact that there are vast differences in the ways in which societies think of this concept and that immigrants from one country to another, countries already dissimilar in so many aspects, may well experience a disconnect in understanding from the host nation, not only on this issue but on many others of familial, social, cultural and psychological life.

It has been argued that Foucault's work was critical, in fact, in undermining the unified foundation of Western culture to some extent. His experience in psychiatric hospital whilst studying psychopathology led him to be interested in so-called phenomenological psychiatry, 'whose merit consists in understanding psychiatric disorders as expressions of specific ways of being-in-the-world contained in a common world of meaning' (Beaulieu & Fillion 2008, p. 77). This is in stark contrast the strictly biological, medical model adhered to by some Western proponents of psychiatric practice, and opens up a vast variety of ways to understand the way people experience mental unrest, which are worlds apart. He was interested in 'the very origins of madness' (Foucault in Lotringer, 1996). A large part of his work consisted in challenging the historical record - who this might have appealed to, who set it down, and what the notions used to record specific events alluded to at the time (e.g., concepts such as madness, folly and insanity in seventeenth century France; for example, a phrase translated as 'insane' rather than 'without sense' invites an entire range of connotations that were not necessarily originally intended).

In the classical era, reason and madness were understood as diametrically opposed, but works such as Foucault's and decades of investigation, philosophy and science thereafter have called this increasingly into question: logical thought, emotions, and behaviours are hardly separable units or events, and are embedded in a complex hierarchical interplay that may break down in a vast number of complex ways. According to the philosopher, Kant, 'the madman is caught in a set of contradictions that make

knowledge impossible...there exists no way of curing the insane person of his illness and "no method of therapy can be effective" (Beaulieu & Fillion 2008, p. 82).

Foucault describes oppression, medicalisation and confinement - bound up with the rise of asylums - as trends emerging significantly in the seventeenth century, and emphasises that the division of reason and madness may be traced to the Classical Age. The fact that Foucault was accused of romanticising mental illness by other Western writers, is in itself sufficient to speak to the dissent apparent amongst this culture, which cannot accurately be collapsed into a unified one—just as the Middle East consists, too, of cultural, religious, ethnic and sociological disparities under the umbrella of what is often thought of as cultures of the East.

Nevertheless, at least some Western psychotherapists may incorrectly presume that clients from another culture lack the ability to understand or assimilate the therapeutic process. On the other hand, they might place excessive emphasis on the ability of clients to be open and expressive in terms of their needs or feelings. Moreover, they may expect them to engage with therapy and to have a level of commitment. However, since the relevance of the clients' perspective is now increasingly recognised in much recent psychotherapy research (Drew 1991), the therapists' expectations of the clients' motivation to participate and to offer their own perspective may be justified to a certain extent. Although the above may be the most common implied assumption of most Western psychotherapists, there has been a spate of research highlighting the fallacies of not taking clients' perspective about psychotherapy into account (Davis 2006).

There is nevertheless an important issue to consider when attending to the client as the centre of therapy, when thinking about culturally diverse clients. Culturally-diverse clients are often not willing to be open in psychotherapy, owing to cultural taboos and

inhibitions (Nelson-Jones 2011). Consequently, they might not always be ready or motivated to engage actively in and commit to psychotherapy (Nevile 2012). This implies that, while Western trained therapists might patiently be waiting for the client to open up and bring his or her perspective to the psychotherapeutic process, the culturally-diverse client may remain closed and inhibited. In more explicit terms, acknowledgement of the need to address the cultural inhibitions, taboos, and stigmas regarding mental health and psychotherapy with culturally-diverse clients, might be absent from a Western-trained therapeutic approach.

### ***3.8 Western-Trained Therapists' Expectations about the Therapeutic Alliance***

One might argue that Western therapy adopts an 'adult' approach, with therapist and client both positioned as adults, as well-informed independent individuals with the capacity to make decisions about healthcare interventions. For instance, CBT is based on a patient-therapist partnership that places importance on the equality of the relationship. This model assumes that the client in the way he participates can make a substantial contribution in the psychotherapeutic process (Nikander 2007)<sup>2</sup>. This suggests that some Western trained psychotherapists may emphasise client-therapist equality. However, in contrast to this expectation, culturally-diverse clients may not be ready to be treated as 'equal' contributors to the therapeutic process. In some cultures, such as in Iran, a doctor or other professional or authority figure is considered an expert and is therefore seen as

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<sup>2</sup>A common Western critique of CBT actually has to do with the exact opposite problem—that it tends to place the client in a passive, 'taught' role, with the therapist becoming a teacher / instructor (Nikander 2007).

more knowledgeable than the layman. The approach may be considered vertical, as opposed to the more horizontal nature of Western therapy (Christodoulidi & Lago 2010). Individuals in such cultures are accustomed to treating authority figures with respect and tend to defer to their judgment (O'Reilly 2012). Culturally-diverse clients usually observe the psychotherapist as an expert having the competence to solve their problems with his specialised understanding of human nature (MacMartin 2008). When Western trained psychotherapists try to be facilitators and not to act as leaders or authority figures, clients used to accepting the opinions of authority figures might interpret it as 'weakness'. This in turn may lead to a loss of faith in the therapist's ability to do her job. In practice, however, the picture is seldom so clear cut. Western clients, depending upon their particular mental scaffolding, difficulties, coping resources and experience of self and others, may well regard the therapist as an adult or authority role in relation to themselves. They may be not only consciously willing, but also unconsciously primed, to take on authority the way their therapist conceptualises and interprets their difficulties. Though the explicit nature of the relationship may be regarded as an adult-to-adult one, given the overarching nature of Western society, this may well not indeed be the case. Issues of transference and countertransference are also important to note here: client and therapist will not experience one-dimensional relationship, with static roles; the very nature of psychodynamics is that therapists will respond to ways clients relate to them with their own countertransference. The way a therapist relates to a client may begin as an adult-to-adult or adult-to-child formation, but will likely evolve and fluctuate throughout the therapeutic process.

### ***3.9 Western-Trained Therapists' Expectations of Culturally-diverse Clients'***

#### ***Motivation to Engage in the Psychotherapy Process***

In the traditional Western approach to psychotherapy, therapists tend to assume that the views they hold about the therapeutic alliance and their relationship with their clients constitute a sufficient foundation upon which to commence work (Orlinsky, Ronnestad & Willutzki 2013). Research has found that psychotherapists tend to assess the therapeutic relationship in terms of the client's commitment and confidence. Furthermore, they consider his working and collaborating ability in terms of the therapeutic relationship, and consider this equally important to their own confidence and dedication (Bachelor 2011). Thus, according to Western trained psychotherapists, psychotherapy's success depends mainly on the client's commitment and her ability to develop a collaborative working relationship with the therapist. Psychotherapists also tend to view their own confidence and dedication as immensely important in the success of psychotherapy. However, it can be argued that the possibility of building a therapeutic alliance, and consequently the onus of therapeutic success, falls predominantly on the client (Pachankis & Goldfried 2007). Cognitive-behavioural and Person-centred therapists focus on encouraging the client's participation in activities or in self-reflection to develop insight into their feelings and behaviour, with the presumption that clients need to participate and engage with the therapy (Pain 2013).

Moreover, a critical observer might note that the notion of therapeutic success is by no means straightforward. The nature of the therapeutic outcome is acutely individual. Theorists operating from within different paradigms might disagree even upon the aim of

psychotherapy: is its ultimate aim is to improve the client's life by helping them confront difficulties of which they may not be aware? Is it to make them more attentive to their cognition, the way they process information, the manner in which they experience emotion, and how that affects their behaviour? Is its eventual goal to help them gain better control over their behaviour, express themselves better, or improve their personal relationships and general functioning? It is clear that, given the inherently experiential nature of the therapeutic experience, outcome certainly presents a challenge for empirical measurement. This is not to say the task is impossible; only that it requires careful thought and may in no way be represented by a unitary outcome measure. Furthermore, not all Western therapists operate according to this model or under these implicit assumptions; it is therefore an oversimplification to refer to a Western approach to therapy as though it were unified, when clearly therapeutic approaches are as diverse as conceptualisations of mental illness (Beaulieu & Fillion 2008).

Psychotherapists may expect clients to approach in terms of commitment, engagement, and dedication towards psychotherapy because they have this preconceived notion in mind. They may also believe that the client has the ability to follow-up on the therapist's prescriptions (Parsons 2012). These expectations may be misplaced, as Bachelor (2011) has revealed that clients do not conform to therapists' presumptions. Instead, clients tend to believe that the psychotherapeutic alliance is best established when the therapist is helpful and scope for joint collaboration as well as support from the therapist is present (Bachelor 2011). Therapists have tended to emphasise the clients' intentions with respect to engagement with psychotherapy. Conversely, clients seem to



give importance to a more joined-up participation of therapist and client, and to also place significance on the therapist's cooperation. The research by Bachelor (2011) has highlighted this discrepancy between therapists' preconceived notions and clients' understanding about the therapeutic alliance, indicating a shortfall of Western developed psychotherapeutic approaches.

It needs to be noted that the research by Bachelor (2011) was conducted using mainstream clients and Western-trained therapists. Moreover, it does not explicitly address the role of cultural differences. However, it can be inferred from this research that these sorts of issues can be multiplied in cases where clients are from a culturally-diverse background. Hence, whilst Western psychotherapy requires voluntary and ongoing client commitment and resourcefulness, culturally-diverse clients may expect psychotherapists to provide them with more direct, upfront, and comprehensive support (Pereplechikova, Treat & Kazdin 2007). This conflict between the expectations of clients and Western trained psychotherapists can lead to dissatisfaction and loss of interest in continuing therapy (Rober, Elliott, Buysse, Loots & De Corte 2008).

It is important to reflect upon why expectations might be so different, and whether this may be attributed to cultural differences or is perhaps central to the human condition and to those who have a certain, perhaps misguided perception, of the therapeutic process and purpose. Humanistic-existential psychotherapeutic approaches have in common engaging with clients in a deeply valuing way—this is more a question of ethical rather than psychological principles—and believing they have the capacity to understand and thus help clients change the way they think, feel and behave (Cooper 2007). Phenomenological exploration is critical to this kind of therapy (Cooper 2007). It is

imperative that psychotherapists are genuine in encounters with clients, and that they are 'willing to meet [them] at a level of "relational depth"' (Cooper 2007, p. 11).

Existentialism was a reaction to the Western tendency to dehumanise the behaviour and experiences of human beings (Cooper 2007). The existential philosopher, Kierkegaard, for example, 'reacted against Hegelianism and its tendency to subsume the experiences of concrete individuals within a model of universal and abstract processes' (Cooper 2007, p. 11). Heidegger (1962 in Cooper 2007) argued against the then-prevailing understanding of people as objects, and 'that human beings think, feel and act in causally-determined, a-volitional ways' (p. 11).

The work of humanistic-existential psychotherapists challenges the belief that behaviours are the result of a lawful, determined process (be these, internal drives, past events or current external stimuli) might be recognised from this point of view as failing to take account of human freedom of choice (Cooper 2007). Intervention at the level of cognition is considered reductionistic, since the human is an emergent property not purely of cognition, but of affect and somatic sensation and the myriad interactions amongst these (Cooper 2007). Human *experience* is the epicentre of psychotherapeutic traditions—experiences are perceived not as mere epiphenomena but as the actual fabric of human experience (Cooper 2009). These assumptions on the part of the therapist, like any assumptions on the part of therapist *or* client, might hinder the therapeutic process: 'If psychotherapists, then, engage with their clients through an epistemological "lens" that is implicitly dehumanizing, it seems possible that this may have a negative impact on their clients' (Cooper 2007, p. 12).

The humanity not only of the client but also of the therapist is fundamental to the therapeutic process: experiencing a sincere and in-depth connection with another person is often critical to the healing process (Mearns & Cooper, 2005; Yalom, 2001 in Cooper 2007). Not being able to achieve meaningful relationships with others in daily life is psychological distressing, and the therapeutic alliance might serve as a beneficial model for new ways of relating: the encounter may therefore serve as a 'corrective relational

experience' (Jordan, 1991 in Cooper 2007). Correcting or adjusting the misperceptions of clients (such as how they perceive the therapist and their perceptions of how the therapist perceives them) may be of immense therapeutic benefit revealing aspects of the transference and of a 'tendency' for clients to perceive people in certain ways and think they are perceived in certain ways (Cooper 2009). Self-disclosure of vulnerabilities, feelings, thoughts and perceptions on the part of the therapist - not unprofessionally or in a burdensome way, but merely in a way that reveals the therapist as a 'real' person with whom the client is having a 'real' relational experience - may be useful in helping clients generalise this new experience and way of relating to others (Cooper 2007). Being continuously genuine and transparent requires psychotherapists to develop their own self-awareness extensively: 'Psychotherapists cannot disclose feelings that they are not aware of; and the more aware and accepting they can be of their feelings, the more confident they are likely to be in expressing them...self-exploration is essential in helping psychotherapists identify the barriers that they, themselves, may put up towards a more in-depth, genuine encounter' (Cooper 2007 p. 15).

There is a long history of philosophical, phenomenological and humanistic inquiry into the nature of subjective human experience (Cooper 2009). Existentialism suggests that experiences do not occur within us, but between us; that subjective experience is ultimately inter-subjective (Crossley, 1996 in Cooper 2009). Both the content and manner of experiences are important: we think in the socially constructed medium of language (meaning that the thoughts, feelings and experiences of others are inseparable from our own); the fact that we think so much about what other people think and how they feel and behave means that our experiences are endlessly and irrevocably intertwined with those of others (Cooper 2009).

In social psychological terms, how do one person's experiences relate to another's? (Coopers 2009). Intersubjective, relational processes and systems have long been the subject of psychological and psychotherapeutic inquiry, but not in purely phenomenological terms (Cooper 2009). This article aims to understand behaviour relationally rather than psychodynamically; the latter characterises present interactions on

the basis of pathological past ways of relating, the former by examining here-and-now misperceptions. (Cooper 2009). This is understandably significant in the context of humanistic psychotherapy, with the hope of identifying task markers such as ways of responding—not as techniques that will of necessity be universally helpful, but in relation to specific clients, contexts or difficulties (Cooper 2009).

One can never directly experience another's experience—even with intuition, empathy and a well-developed, sensitive psychological mind, one's perceptions of another's lived experience will be biased in the direction of the way that individual presents himself, and this appears to be because of just that—such data is more perceptually salient than any feelings, actions, thoughts in the other that may only be *inferred* (Aronson, Wilson & Akert, 1999 in Cooper 2009). This does not negate the capacity of humans to feel empathy. Cognitive, interpersonal and social development, in concert with will, appear necessary to empathise (Cooper 2009). Misperceiving the feelings and actions of others may lead to interpersonal difficulty and pain, often alleviated through therapy (Cooper 2009). Not only being empathised with, but developing the ability to experience and extend such empathy to others, is critical in relationships (Cooper 2009). All forms of therapy, to some extent, encourage development of the ability to be transparent about thoughts and feelings, in order to have a more congruent experience (Cooper 2009).

Research shows that metaperceptions and others' actual perceptions of oneself are highly incongruent; furthermore, people tend to assume that there is much less variability in the way particular people experience or think of them (Cooper 2009). An explanation of this emerging from social psychological research is that people's beliefs about the perceptions others have of them are based largely on how they perceive themselves (Kenny & Depaulo 1993 in Copper 2009). This may be due to the utter salience of people's own vulnerabilities, doubts and uncertainties to themselves, making it impossible for them to believe others cannot see these too (the 'myth of self-transparency'; Depaulo et al., 1987), likely based upon the same kind of perceptual bias we naturally apply to our perceptions of others (Cooper 2009). Strong beliefs of self-

transparency have been associated with interpersonal difficulties (Cooper 2009). In terms of the PEP approach in this study, it may be useful to point out to clients their metaperceptual discrepancies as part of the transference, with the hope that this will be generalised by the client to their other relationships. Positive self-disclosures and feedback in the moment may be useful in helping clients challenge their own metaperceptions (by receiving often surprising and unexpected feedback about how people, including the therapist, perceives them).

Clients have reported that the most useful therapeutic moments for them are those in which there is a 'flow' between the therapist and client: this was most constructive for them in retelling/reauthoring their narratives, and in coconstructing or reconstructing narratives with their therapist (as opposed to, for example, their feeling as though the therapist was the audience, or that they were negotiating the happenings of their lives on their own (Grafanaki & McLeod 1999).

The importance of therapists understanding sociocultural factors that may influence a client's perception, expression and interpretation of his symptoms/presentation has been increasingly recognised (Farsimadan 2011), and may well impact upon the motivation a client from another culture has to begin and continue with therapy. The misunderstanding, misinterpretation and premature termination of therapy if this is not adhered to, has also become a topic of important inquiry in multicultural research (Farsimadan 2011).

Iranian culture is ethnically, linguistically and religiously diverse, as a result of its historical emergence from the ancient Persian Empire (Farsimadan 2011). The Indo-European Aryans, the ancestors of the modern day Iranian populace, were Zoroastrian by religion, and converted to Islam when the Muslims conquered Iran in the seventh century (Farsimadan 2011). The overwhelming majority of Iranians today are Muslim (Shi'ite and Sunni), with a remaining minority of Christians, Jews, Zoroastrians and Baha'i (Farsimadan 2011).

Farsimadan (2011) explains that the Iranian family is founded upon male supremacy, and that 'double standard[s] of morality' (p. 282) persist today: girls are taught and encouraged to be quiet, polite, good mothers and wives, innocent and beautiful; whereas boys are socialised to work hard, be commanding and protective, and obtain social status. An interesting consequence of the sacrifices made by Iranian women for their families, is the high expectation they in turn have of their families: as the mediators of family emotion, they control, dictate and set the emotional tone, to a large extent, of the affairs of their children (Farsimadan 2011). Sons are afforded far more freedom than daughters; a common source of conflict in these families, particularly between first- and second-generation immigrant families, in which the latter have been exposed to notions and ideals of equality, and what this might mean for their own lives (Farsimadan 2011). This tension carries over into all aspects of second-generation immigrant life: for example, sexual practice in the culture of origin dictates abstinence until marriage, whilst media and peer exposure promote dating and premarital relations -- this a major source of tension for immigrants, who find themselves inhabiting neither culture fully, a situation which impacts drastically upon their sense of identity (Farsimadan 2011).

The last 30 years have seen emigration of approximately three million Iranians: During the 1950s, these were mostly middle and upper-middle class students, wealthy businessmen and skilled professionals who chose to leave; between 1978 and 1980, in the context of the Islamic revolution, a similar demographic emigrated, but with the addition of those associated with the overthrown government and therefore forced to flee; from 1980 to 1988, in order to escape the war and its associated economic difficulties, lower and lower-middle class young men (single or married) emigrated, determined to benefit from better economic prospects overseas: this demographic does not constitute refugees in the usual sense, but nevertheless are vulnerable to psychological sequelae including depression, anxiety and alienation, owing to separation from their immediate families and extended networks and culture (Farsimadan 2011).

Three models of adaptation for Iranian immigrants have been proposed: denigration of the old culture, denial of the new culture, and biculturation (Jalali 1982). Different members of one family may tend towards one of these modes of acculturation over another, and this often causes significant stress within the family (Farsimadan 2011). Furthermore, the need to internalise new ways of thinking, behaving and being—the task of integrating a new and, in many senses, radically different culture with one's own—is inherently stressful (Farsimadan 2011). Attempting to reconcile the values of the two cultures is an immense task, with which immigrants are invariably faced as they grapple with feelings of wanting to fit in and staving off the guilt of at least to some degree relinquishing their old, known culture (Farsimadan 2011). This generates internal conflict and inevitable emotional and psychological difficulties, especially in younger (second- and third-generation) immigrants; the concerns of older, first-generation Iranians tend to centre on loss of status and position, fear of financial dependence on others and the state, physical and emotional isolation, alienation and culture shock (Farsimadan 2011). Overall, the transition appears less stressful for men, who nevertheless maintain more traditional views of women's roles and of the separation of the sexes in society than do women, who naturally therefore experience acculturation as more stressful (Farsimadan 2011). The conflict between old values and new behaviours in a new society poses a great potential for stress within families (Farsimadan 2011). Exposure of women to freedom, independence and self-determination in the new society, since these ideas are usually so foreign to them, means that acculturation takes longer; these liberal values are also often the reason why women immigrate, in order to lead a less controlled and dependent and a more-self-directed life (Farsimadan 2011). Adopting new values and having these conflict with traditional ideas, still held by men, has been proposed as a key factor in the breakdown of Iranian families; nevertheless, research also indicates that many Iranian women still regard Western women as too individualistic, and criticise their lack of sacrifice and family dedication—this illustrates the tendency for biculturation, adopting some but not all features of the host culture (Farsimadan 2011). There is an inverse relationship between age and acculturation (Farsimadan 2011). The challenges of

acculturation are exacerbated by negative stereotypes, actual and perceived hostility, and subsequent alienation (Farsimadan 2011).

### ***3.10 Western Psychotherapy's Emphasis on the Therapist's Objectivity***

As discussed so far, approaches like cognitive behavioural therapy or person-centred therapy excessively focus on the client. In this approach, the therapist acts as a facilitator while the client undergoes the process of self-awareness and recovery (Robinson, 2008). Western psychotherapists are trained to remain objective and to not emphasise their perceptions and opinions with clients. The rationale behind this is to create a sense of comfort and also to create a non-judgmental environment (Scollon 2009).

However, in some cases people from culturally-diverse backgrounds may have the need for explicit reassurance, making them believe that the person they are opening up to is truly non-judgmental (Searle 2009). This is particularly true in case of clients from Asian and Middle Eastern countries, where establishment of an explicit and verbal sense of commitment as well as trust is a prerequisite, before clients can share their inner thoughts and feelings (Perepletchikova, Treat & Kazdin 2007). This need for a sense of trust is rooted in the more collectivist cultural and social upbringing of Asians, including Iranians; where there tends to be an immense pressure to conform besides seeking approval and acceptance (Seligman 2010). In collectivist cultures, family and local community are generally considered first, before the individual (Christodoulidi & Lago 2010). This presents a sharp contrast between Western societies such as the UK and those of the East, under which Iran generally falls. As such, culturally-diverse clients may have



inhibitions regarding the therapists' opinions about their problems and might expect reassurance from their therapists. However, this reassurance tends not to be forthcoming because of the therapists' training in terms of taking an objective stance, keeping their own opinions under wrap.

The researcher conducting the current study errs on the side of providing culturally-specific feedback and relating shared experiences to clients, where appropriate, in order to ease this potential concern. The sharing of relevant life experiences depending on different client's issues has been found during sessions to help break the ice and to help clients meaningfully challenge taboos according to which they operate. Helping them understand that even the authorities or professionals make mistakes or have been victims in the past appears to be of significant help to them, and relates to work on the therapeutic alliance providing a new model for relating not only to others in the world (Michels 2000), but also to oneself. It feeds into the experience of transference and countertransference, too; since client perceptions and assumptions will naturally be challenged through such relationship experiences, bringing to light their expectations about relationships with others. The researcher has found that sharing culturally-relevant experiences in this way helps clients focus on the fact that what is most important is changing one's old roles in life, roles that no longer serve one's best interests, and creating new roles for a new better life than before. By sharing relevant experiences, the researcher realised that clients feel relief and hope, too; and that it provides them with the lead and the power, making it clear to them that this is not in the therapist's hands, but in theirs. It affords them the power and knowledge to take the responsibility for their own

issues and problems. This is a good example of how cross-cultural therapy may differ from traditional approaches. In addition, research suggests that self-disclosure on the part of the therapist may attenuate others' misperceptions that everyone else is confident, happy and fulfilled, which may be of immense help to them in adjusting their framework of reality (Cooper 2009).

This is not to say that sharing such experiences is not without its own difficulties. Research has demonstrated that the unique situation created by cultural matching between client and therapist may lead to misguided expectations and perceptions—conscious and unconscious—that may not always be helpful and may in some circumstances impede the therapeutic process (e.g., Verdinelli & Biever 2009).

For example, work by Costa (2010) and Costa and Dewaele (2012) examined the influence of mono- and multilingualism on the therapeutic relationship. A mixed-methods study of 101 monolingual and multilingual therapists reveals that lingualism accounts for 41% of the variance in how well attuned therapists are to their clients - this suggests that speaking the same home language as one's clients does not necessarily of straightforwardly confer an advantage on the therapeutic process; it introduces the possibility for collusion and expectations that may work counter to the actual therapeutic process, and may hinder the therapeutic power of the alliance (Costa & Dewaele 2012). Clients may overidentify with the therapist in these situations, and may overstep boundaries. In one study, a therapist reports that several clients with whom they shared a cultural and linguistic background expected favours and financial assistance from the therapist as a result (Nguyen 2014). Some participants reported being aware of needing to separate themselves and their own issues from the client even more so when they shared their background, than when they did not; it required greater vigilance on their part (Nguyen 2014).

Furthermore, multilingualism is associated with the personality trait, Tolerance of Ambiguity (TA; Dewaele & Wei 2013). It has been widely established that physiology and sociology exert an equally important influence on the development of personality (Dewaele & Wei 2013). However, the effect of social, linguistic and cultural factors on

individual personality have not before been studied in detail. The cognitive effects of these factors have been studied in detail, but not the psychological (Dewaele & Wei 2013). The aim of this study was to determine whether being bilingual, monolingual or multilingual affects one's personality - and in this case was investigated specifically with regard to TA (Dewaele & Wei 2013). This is significant in the context of the current research, since tolerating ambiguity is important in making progress within the therapeutic framework - or, perhaps more accurately, is an important outcome thereof (Dewaele & Wei 2013). The hypothesis was that 'the experience of having to function in a foreign language and culture for a certain length of time makes people more tolerant of ambiguity' (Dewaele & Wei 2013, p. 231). It has been previously shown that people who have a greater capacity to tolerate ambiguity are more likely to perceive it as positive (Budner, 1962). The hypothesis was supported, demonstrating that multilingualism has more than purely cognitive consequences (Dewaele & Wei 2013). What this said about the psychological effects of multilingualism and multiculturalism is very important to take into account in the context of this study, since it hinges on the experiences and perceptions of immigrants who have, by necessity, become multicultural (and in many cases, multilingualistic; Dewaele & Wei 2013).

Mutual bilingualism has been reported positively to effect counselling outcomes in cases in which it facilitated the therapeutic alliance: specifically, when it helped therapists identify with clients (Costa 2010). The pitfalls of drawing overly simplistic conclusions regarding language matching between client and therapist, is already evident in this statement. Shared language and bilingualism may be advantageous in facilitating successful therapy; however, this will likely depend upon a multitude of other variables in individual therapists and clients. Identification was reported relating to the experience of loss as a result of living in a foreign country, speaking a foreign language and understanding language issues (Costa 2010). One participant said that her ability to relate to her clients' 'foreignness' enabled them to be 'more relaxed and trusting' (Costa 2010, p. 19). Similarly, therapists may feel more attuned to their clients, enhancing connection and alleviating their feelings of isolation (Costa & Dewaele 2012; Nguyen, 2014, p. 350).

A qualitative case study revealed that the moments clients find most useful in therapy are those in which there is a 'flow' between the therapist and client: this was most constructive for them in retelling/reauthoring their narratives, and in coconstructing or reconstructing narratives with their therapist (as opposed to, for example, their feeling as though the therapist was the audience, or that they were negotiating the storyline/happenings of their lives on their own (Grafanaki & McLeod, 1999), which might well be the case if therapists appear strictly objective and impersonal..

Some of the difficulties and complexities that may occur when a Western trained psychotherapist is paired with a non-Western client have been discussed above. There is a need for culture-based psychotherapy that can address the stigma, inhibitions, and taboos that render culturally-diverse clients unable to be expressive with their therapists. In addition, there is a need to remove the unrealistic focus placed on the client's self-motivation. Additionally, it is necessary to bring therapy into accordance with client expectations regarding the therapeutic alliance, besides being adaptable to the attitude and behaviour of therapists. There is a growing consensus amongst healthcare counsellors and policy makers regarding the need for culturally competent mental healthcare (Smedley et al. 2003). The requirements of a culturally competent psychotherapy programme remains to be explored. The next section covers this ground, as regards different opinions in terms of the content, methodologies and outcomes of culturally competent psychotherapeutic programmes.

### ***3.11 Theoretically Developed Integrated or Hybrid Models of Culture-Based Therapy***

Many scholars argue that an integrated or hybrid model of basic methodologies and treatments of Western psychotherapy delivered with cultural sensitivity is needed and that mental health providers are currently in a dilemma as to how to do this (Benish, Quintana & Wampold 2011; Miranda, Bernal, Lau, Kohn, Hwang & LaFromboise 2005; Nagayama-Hall 2001). This is uncertainty as to how effectively to address the large number of issues concerning their role as a service provider.

One of these issues concerns the need to implement an 'as-is approach' that addresses the mental health needs of all culturally-diverse groups and not just a selected few culturally-diverse populations (Nagayama-Hall 2001). There is also the issue of using interventions that are considered culturally congruent, thus serving the needs of specific ethnic clients to ensure tailored and customised service delivery.

In line with the need to achieve cultural congruence, there is the dilemma of designing new culture-specific interventions to ensure that each ethnic group has an independent model of culture-based psychotherapy (Miranda et al. 2005), based on serving all these needs with a single 'one-stop' approach recommended by the hybrid model combining basic methodologies.

Davis (2006) argues that implementing an as-is approach in disseminating empirically supported treatments (ESTs) to ethnic minority clients may not fully address the diverse needs of clients. Therefore, culturally adapted ESTs may be the most responsive and cost-effective approach. Culture-based therapy or more specifically, culturally relevant, culture-sensitive or culturally adaptive psychotherapy has been

defined by Bernal, Jimenez-Chafey and Rodriguez (2009) as 'the systematic modification of an evidence-based treatment (EBT) or intervention protocol to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns, meanings, and values' (p. 362) Other scholars have defined cultural therapy as an adoption of traditional therapy with an assimilation of the values and beliefs of the clients, delivered in the client's language and conducted in a setting that is considered safe by the client (Whaley & Davis 2007).

These scholars recommend an adaptation of the existing Evidence-Based Treatments that would make them 'culturally fit', whilst retaining the original mechanisms of behavioural change or symptom reduction. Such integrated or hybrid cultural psychotherapy frameworks are proposed by Hwang (2006), Bernal, Bonilla and Bellido (1995), Domenech-Rodriguez, Baumann and Schwartz (in press), La Roche, Hwang (2009), Vasquez (2010) and others.

Al-Thani (2011) has implemented psychotherapy for Middle Eastern clients in Qatar, and documented the process and outcomes by means of detailed case studies. Before outlining his research on cross-cultural therapeutic practice, he describes the classical person-centered approach (PCA), upon which his framework is based. PCA was established by Rogers in the 1930s and 1940s—this approach emerged from the belief that accepting, valuing and understanding clients' experience is the basis for emotional or psychological healing—this heralded a move away from conceptualising the person seeking help as a patient (the medical model) towards one in which they are considered in control of their resources, lives and progress (Al-Thani 2011). Rogers described six therapeutic conditions, which he considered should be in place for there to exist a therapeutic relationship between therapist and client: the therapist and client are in

psychological contact; the client is in a vulnerable, anxious, incongruous state; the therapist is congruent or integrated in the relationship; the therapist has unconditional positive regard for the client; the therapist is empathic towards the client's internal frame of reference, and communicates this empathy to the client; and the communication of empathy and positive regard is achieved. Constructive personality change is thought to follow from these six conditions, without the need for any others (Al-Thani 2011).

These were distilled by later theorists and practitioners of the approach to three core principles, which included unconditional positive regard (an attitude), congruence (a state of being) and empathy (a process): Congruence refers to the ability of the counsellor 'to authentically be him/herself with the client' (Al-Thani 2011, p. 3). Behaviour corresponds with inner feelings in a state of congruence, and involve awareness of both (Al-Thani 2011). Congruence has been described as the ability 'to admit organismic experiences fully into awareness, without the need for distortion or denial' (Tolan, 2003 in Al-Thani, 2011, p. 4). This self-awareness and congruence is considered fundamental to being able effectively to enter and experience the inner world of another (Al-Thani 2011). Non-verbal communication and support, e.g., nodding, and the proven efficacy and value of this means of listening and connecting -- however, the interesting phenomenon of cultural clashes re non-verbal cues, e.g., Qatar clients feeling ignored if acknowledgement is not verbalised (Al-Thani 2011). Unconditional positive regard: an acceptance of and regard for his attitudes of the moment; being liked and 'prized' as a person appears critical to a helping relationship, and to helping the other person possess the own feelings. Consistent acceptance, regardless of behaviours, thoughts and feelings (Al-Thani 2011).

Non-verbal communication may be misconstrued across cultures, e.g., it is unacceptable for a Muslim man to shake a Muslim woman's hand (Al-Thani 2011). Non-verbal communication may be divided into three categories, including kinesics (all body movements), oculesics (eye contact) and haptics (touching; Al-Thani 2011). These can create a depth of relating between therapist and client that is far greater than can be achieved merely with words (Al-Thani 2011).

Following in-depth case studies of five Middle Eastern clients who attended such person-centered therapy, Al-Thani (2011) concludes that non-directive counselling has various aims and functions: helping individuals express their own feelings and thoughts, helping them resolve their own problems, and helping them to create conditions for happiness and fulfillment. The interview/session data from participants themselves resoundingly supported the hypothesis of this study, that such therapy is in dire need in Qatar, in particular following the difficulties social change (this may be dated to the discovery of oil in 1940) has wrought - difficulties which cannot necessarily be as efficiently dealt with by family and direct advice, as per the usual Middle Eastern support structure (Al-Thani 2011).

The clients emphasised how important religious and cultural factors are - they believed counselling should be adapted to the teachings of the Holy Quran and the Prophet, and that the values and traditions of clients should be included (Al-Thani 2011). Al-Thani (2011) discusses his belief that patience, acceptance, encouraging clients not to try too hard, modeling how to solve problems, trusting the intuition of the client, the importance for the client of engaging in different activities, and client motivation (Bohart & Tallman, 2003). Practical techniques employed with these clients included applying religious support, directing the client towards the aim of the therapy (i.e. encouraging clients to help themselves), putting the will of Allah before the therapist's own abilities, body language (important indicators of feelings, attitudes and personal relationships), self-reflection (especially as a specifically Muslim person-centered counsellor) (Al-Thani 2011). Al-Thani (2011) concludes by conveying his wish that this study may demonstrate the positive effects of 'encouraging Muslim clients to work from within and learn new methods of building a healthy relationship with oneself and with others' (p. 308). He summarises his modified PCA as follows: the location must be appropriate and private; the counsellor must possess an in-depth understanding of the religious background of the Muslim client; the counsellor aims to help the Muslim client improve his relationship with Allah, and encourage him to follow the Prophet's feelings, as well s to work from within and establish a healthy relationship with himself; there must be a shared



understanding of the importance of family relationships for the Muslim client; and the counsellor's congruence should include all these aspects when working with Muslim clients (Al-Thani 2011).

The need for nondirective therapy applied specifically to the Islamic people in Qatar is discussed in this article, based upon nine case studies of the therapeutic course and outcome of such counselling in this population (Al-Thani & Moore 2012). The authors concluded that 'a shared Islamic framework is critical to the success of the counseling and that nondirective counseling can work in Islamic culture when it is introduced with "insider" sensitivity' (Al-Thani & Moore 2012). This work provides an excellent example of cross-cultural therapeutic work, and certainly one of the best explicated.

### ***3.12 Adapting Traditional Therapists with some Modifications for Cultural Relevance***

Another approach to culture-based psychotherapy is to modify traditional therapies, adding dimensions including cultural parameters. Bernal, Borilla and Bellido (1995) developed this theoretically-driven framework. These modified therapies are founded on a number of premises. Initially, they are based on well known traditional therapies successful and popular with clients. By implication, the users of these modified therapies (i.e. the clients) belong to the school of thought that considers the client to be central for the efficacy of therapy. They would also consider that the type of therapy should be one with which the client is comfortable (Davis 2006).

Another premise is that culturally sensitive elements are 'fused' into the modified therapies to ensure that the specific cultural needs of clients are met. For instance, Bernal, Bonilla and Bellido (1995) have adapted CBT and interpersonal treatments for depressed

Puerto Rican adolescents. Their work suggests that the culturally sensitive elements could refer to any aspect of the client's socio-cultural lifestyle.

The first therapies of this kind were based on CBT and interpersonal treatments. Rossello and Bernal (1996) have called for one of eight selected culturally sensitive elements, namely language, metaphors, content, concepts, goals, methods and context to help identify areas of adaptation.

Rossello and Bernal (1999) have pointed out other factors important to the success of modified therapies. For instance, in their particular case, the researchers used randomised controlled trials, which were effective in treating patients. Other contemporary practitioners have taken over the modified therapy approach by offering more simplified, 'person-focused' frameworks based on a combination of traditional therapies and cultural elements. A typical example of such modern frameworks is given by Hwang (2006) that devised the Psychotherapy Adaptation and Modification Framework (PAMF). Instead of eight cultural dimensions, a three-tiered approach to cultural adaptations was used: domains, principles and rationales. Pachankis and Goldfried (2007) explained these adaptations by associating the domains with general areas of a client's life that must be utilised by the therapist when modifying therapeutic approaches. Rationales are factors explaining effectivity in a specific population (Davis 2006). Defining the merits of the three-tiered approach, Pachankis and Goldfried (2007) noted that shifting therapies from abstract to the development of concrete skills and strategies may prove beneficial (Hwang 2006).

Hwang (2006) discussed the need for adapting Western-developed psychotherapies for clients from diverse ethnic backgrounds and provides a conceptual framework for developing as well as applying such therapies. Hwang's modified model of culture-based therapy was aimed at working with the Asian-American immigrant population in the US. Hwang's (2006) PAMF provides basic guidelines in terms of domains or general areas such as the complexity of the client's culture that may inhibit the formulation of a therapeutic alliance or client engagement. It also provides a set of principles offering specific recommendations for adapting traditional psychotherapeutic measures. Ultimately, it provides rationales, which offer areas of logical reasoning that the therapists can undertake in selecting the most suitable interventions when modifying their work with cultural relevance in mind (Hwang 2006).

Although PAMF recognises the need for modification of traditional psychotherapies, it emphasises that Western psychotherapies can be used as the basic models upon which such modifications are based (Hwang 2006). Hwang's model was based on Nikander's (2007) ideas. Nikander researched why Western psychotherapies offer the most effective basis for ethnically sensitive treatments. He concluded that most Western therapies are multi-variant: they already incorporate concepts and contexts applicable to a wide variety of ethnic backgrounds. As a consequence, it is possible to fuse these Western therapies with elements that focus on culture so that modified therapies may be constructed.

It has also been noted elsewhere that, in comparison with other basic therapies in theory and practice, Western therapies are simple and straightforward. They allow room

for modification that could approach in the form of ethnic contexts addition (Pachankis & Goldfried 2007). Commenting on why a long and complicated basic therapy would not be useful for a combined modified therapy, Parsons (2012) noted that such combined therapies will cause delays and will eventually affect the therapists' output. Based on these factors, Hwang (2006) is justified in taking the position that traditional Western psychotherapies should be modified when searching for culture-based psychotherapies.

Another example is that of a framework for depression developed by Bernal, Bonilla, and Bellido (1995) to treat Puerto Rican adolescents. This programme adopted CBT methodologies as well as interpersonal approaches, and used cultural factors such as language, culture specific metaphors, and culturally relevant end-objectives for treatment. Their framework for culture-based psychotherapy is one of the earliest pieces of evidence on the relevance of cultural differences between client and therapist (Nicolas et al. 2009).

The success associated with this particular framework gave rise to another line of debate among reviewers, regarding whether the emphasis on traditional therapy used in combined psychotherapy should merely be a traditional Western psychotherapy or whether the emphasis should be on the variables presented by the traditional psychotherapy (Nikander 2007). Following the success of the study by Bernal, Bonilla and Bellido's (1995), the outcome evidence favours the cultural factors that were considered part of the CBT methodology, rather than the mere fact that the basic modified psychotherapy was Western in nature.

In a related study, the Parent Management Training–Oregon (PMTO) intervention (Domenech-Rodriguez, Baumann & Schwartz in press) has been used to ascertain the

basis of an argument. This argument deals with the assertion that it is the cultural factors in modified psychotherapy that have an effect on the outcome rather than the fact that traditional Western psychotherapies are used. This intervention, used by Spanish-speaking Latino families, maintains behavioural therapy principles, such as applying immediate contingencies for desired behaviours. However, the specific behaviours thought to be desirable, the specific contingencies used, and the context in which they are presented, are all flexible and hence may be adapted to clients' cultures. Additionally, the frames or metaphors used to explain the concepts to parents (or other caregivers), and the therapeutic process was also modifiable and altered to meet the cultural requirements of the client.

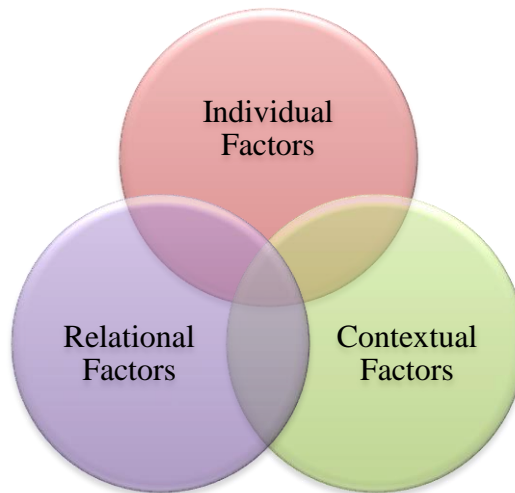
### ***3.13 Cultural (or Cross-Cultural) Psychotherapy Models***

Six major cultural and cross cultural psychotherapy models have been identified in the literature and are presented below.

#### ***3.13.1 Model One: La Roche's Three-Phased Cultural Psychotherapeutic Model***

This model emphasises the fact that it is vital to have a multi-layered context placing a premium on people, situations, and systems, in order for psychotherapy to be effective. Emphasising people and situations bring about the cultural components of this model, as cultural identity is constituted by the kind of people and social situations by which individuals are surrounded.

La Roche's Model is based on several assumptions, most of which are based on the fact that the clients' cultural context needs to be part of the considerations made for psychotherapy. Subsequently, therapists can gain a better understanding of the clients' orientation, values and thought processes. This model also assumes that the dynamic nature of knowledge is important for therapists to succeed in their work with such clients. The dynamic nature of knowledge manifests itself through individual, relational and contextual factors, as depicted below (Figure 1):



**Figure 1: La Roche Model, Source: La Roche, pp. 13**

The practical delivery of the model is carried out in three phases. The first phase addresses basic needs, while the second addresses the reduction of symptoms, focusing an understanding of the client's experience. The third and final phase involves fostering empowerment.

During the first phase, the therapist works in collaboration with the client to gain a better understanding of the problem at hand and tries to progress in identifying possible

options that may reduce the client's symptoms (Parsons 2012). In the second phase, the therapist involves the client even further, so as to ensure that the client can better explore and understand how his relational experiences may have impacted his life (La Roche 2013). The final phase focuses on the client's cultural perspective by taking advantage of social factors that influence the client. Based on these factors, therapist and client work collaboratively to enable the client to gain further insight and skills to further aid with his or her difficulties.

### ***3.13.2 Model Two: The Formative Method for Adapting Psychotherapy***

#### ***(FMAP): A community-based developmental approach to culturally-adapted therapy***

The model presented by Hwang (2009) is unique in a number of ways. Initially, it identifies the client as part of a larger community, rather than a single entity. The interventions that therapists adopt are expected to focus on the total effective integration of the client into the community in which he belongs. This emphasis clearly demonstrates the significance of clients' cultural backgrounds, as each community is unique and has a particular culture.

Second, the model works more formatively, as psychotherapy interventions are assessed and monitored for influencing change on an 'on-the-go' basis, rather than waiting until the end of each session (Davis 2006). A five-phase approach is taken to effectively perform this task. In the first phase, the therapist emphasises the generation of knowledge and continuously collaborates with the client to ensure collection of sufficient information for further decision-making. In the second phase, the information gathered is

integrated into theory, empirical and clinical knowledge, to ensure that the approach can become an evidence-based practice (Hwang 2009). Thirdly, a review of the culturally adapted clinical interventions occurs that are presented to the therapist by the client. This is done to ensure better adaptation of treatment for the particular client, in line with culturally specific interventions that are suitable to him. Furthermore, the therapist who then makes a decision either to use the existing interventions tests the existing culturally adapted interventions or to integrate them with new approaches found in practice (Nikander 2007).

### ***3.13.3 Model Three: Culturally Responsive Cognitive-Behavioural Therapy***

In their book *Culturally Responsive Cognitive–Behavioural Therapy: Assessment, Practice, and Supervision*, Hays and Iwamasa (2006) propose that psychotherapy is a multidimensional process, the effective execution of which cannot be expected by following a single line of action. To this end, they combine CBT psychotherapeutic ideas and emphasise the importance of taking culture into account when conducting the CBT to satisfy the needs of clients from diverse backgrounds. This model has been identified as of the first to integrate cultural influences into CBT.

The proponents of this model justify the importance and workability of their approach. In the first place, they take account of the characteristics of people from both larger and smaller cultural groups, such as Indian, Latino, Asian, African-American, Native-Alaskan individuals, or people from an Arab or Orthodox Jewish heritage. The authors note that the cognitive-behavioural variables of each of these groups are



differentiated based on their cultural characteristics (Parsons 2012). It proposes that refining and integrating the cultural dimensions of clients with regards to using a modified version of CBT may guarantee more individualised results for psychotherapy interventions.

When using CBT models, a culturally responsive assessment to identify the various manners in which other groupings of people with specific characteristics such as older adults, people with disabilities, and gay and lesbian individuals may respond to this treatment, can be included (Pachankis and Goldfried 2007). Therefore, the basis for using this model successfully involves identifying cultural variables unique to each group of clients, using cognitive-behavioural framework.

#### ***3.13.4 Model Four: Cultural Relationship Driven Model***

This model involves the adoption of two different models: the work of Pedersen, Crethar and Carlson (2008) and that of Pedersen (2004). While the former makes relationships central in counselling and psychotherapy as a means of creating cultural empathy, the latter focuses on a variety of experiences for multi-cultural learning. These two models are similar; they both appreciate the fact that psychotherapy and its outcomes involve a learning process (Parsons, 2012). Therefore, it is important to have a setup that comprises a learner and a teacher. In this case, the teacher is the therapist and the student is the client. What differentiates this model from a traditional classroom learning situation is that here the student, who takes part in the learning, is a stakeholder for change. For this reason, the client must be adequately utilised by the therapist so that the

therapist can gain meaningful results in terms of improved client (student) performance (Davis 2006).

Notably, learning is a process that begins with a person's most immediate environment. Consequently, the client's cultural background is considered important in creating a possibility of impact by learning. According to Pedersen, Crethar and Carlson (2008), therapists can make adequate use of clients' cultural backgrounds by empathising with their cultural settings and thus creating an atmosphere of inclusion and empathy. By contrast, Pedersen (2004) believes that this can be achieved through multi-cultural learning when the therapist is part of the client's culture. A weakness with this model, however, is that it does not provide a definitive programme that can be used by therapists.

### ***3.13.5 Module Five: Clinical Multi-cultural Reality Therapy***

With a background in psychiatry, Tseng (2004) has devoted his work, entitled *Culture and Psychotherapy: Asian perspectives*, to cementing the idea that free movement policies, developed by most governments, have created a contemporary multi-cultural society. The relevance of the need to become more focused by looking at the individual cultures of clients, when delivering psychotherapy is lost when considering this objective. There is a need in this model to approach psychotherapy within a clinical multi-cultural reality.

According to the writer, this approach makes psychotherapy straightforward and universal, even though it may lack the benefit of being user-centred. Therapists are required to take a pre-therapy approach in terms of coaching these clients to accept the

need for a multi-cultural reality therapy to facilitate clients who are rigid in terms of the need for them to have their dynamic cultural needs met (i.e. there is a need to do some work before therapy starts).

Unlike the cultural-relationship driven model, which considers the therapist as teacher and the client as student, the clinical multi-cultural reality therapy considers the therapist a medical specialist who diagnoses and prescribes. In this manner, a great deal of attention and work for change is dependent on the therapist rather than on the client. Therefore, therapists base their work on clinical experience as well as on their theoretical knowledge of studies that relate to the cultural background of particular clients.

#### ***3.13.6 Model Six: Cultural Adaptation Model***

This model is based on the work of Smith, Rodriguez and Bernal (2011), entitled *Culture*. Their work is based on the argument that the level of cultural adaptation of clients ahead of psychotherapy, is very influential in determining the level of success. They describe cultural adaptation as the process whereby the client accepts the prevailing cultural parameters that will be used when treating him. In this manner he learns to be an integral part of that culture.

Evidence for this model was gathered by applying culturally un-adapted interventions to a group of white clients and applying culturally adapted interventions to another population with the same cultural background. Results showed that impressive outcomes were attained with the latter model. Identification of specific cultural perspectives accepted by the clients is imperative for the clients to make effective use of

this model. This is important because in most of the cases, interventions based on cultures from which the client originated are not always accepted by the client (Nikander 2007). Following this scenario, the client then participates in sessions that help her adapt well within her culture before beginning psychotherapy sessions.

As presented above, all these models clearly define the cultural factors that should be considered when offering psychotherapy to clients.

### ***3.14 Empirically Developed Community-based Adaptation of Psychotherapy***

Many scholars are convinced of the efficacy of culturally-adapted psychotherapy aligned with the specific beliefs and values of particular cultural and ethnic groups (Comas-Díaz 2006; Gone 2010; Smith, Rodriguez & Bernal 2011). For instance, in their meta-analysis of 8620 participants, Smith, Rodriguez and Bernal (2011) proposed that culture-specific psychotherapy (that is, therapy developed and adapted for a particular cultural group), is more effective than culture-sensitive therapy (that is, therapy that merely encourages therapists to be aware of and sensitive to client diversity). Based on their review of 65 experimental and quasi-experimental studies, Smith, Rodriguez and Bernal (2011) agreed that the impact of culture-sensitive or culture-adapted therapy was greater than that of traditional Western psychotherapy.

There is growing evidence to suggest that treating clients in a more culturally sensitive manner (i.e. providing client-therapist ethnic matching and treatment at ethnic-specific services) may reduce premature treatment failure (for example, see Flaskerud & Liu 1991; Sue, Fujino, Hu, Takeuchi & Zane 1991; Takeuchi, Sue & Yeh 1995).

The concept of ethnic matching is of critical importance to this field. How does ethnic matching affect the therapeutic alliance and how clients perceive therapists? The issue of whether therapists and clients should be ethnically matched has long been debated in the fields of counselling psychology and psychotherapy: those who argue for this method (intracultural therapy) claim that, because matched clients and therapists will have had similar experiences, they will be better able to understand and help clients with their issues; those who advocate cross-cultural therapy maintain that the universality of the human experiences is enough to bind any client and therapist in a common understanding, and that ethnicity is similar to gender, religion, age, education and socioeconomic status in terms of being a difference that must be transcended during the therapeutic process (Farsimadan, Draghi-Lorenz & Ellis 2007). 'Clients in the matched dyads had expressed a preference for matching' (Farsimadan, Draghi-Lorenz & Ellis 2007, p. 567): this constitutes a potential confounding variable, since such clients may have had better outcomes and perceptions based on the fact that this strong preference was met (i.e. having the preference itself may have predisposed their success when this was satisfied).

Historically, evidence on the effect of ethnic similarity is inconsistent (e.g., Sattler, 1977; Atkinson, 1983; Abramowitz & Murray, 1983 in Farsimadan, Draghi-Lorenz & Ellis 2007). However, more recent work indicates that ethnic similarity may strongly predict therapeutic outcome, and that is more closely related to the influence this may have on acculturation, cultural commitment and cultural mistrust (Farsimadan, Draghi-Lorenz & Ellis 2007). Ultimately, it appears as though development and maintenance of the therapeutic alliance is most definitive in predictions of therapeutic outcome, and that cultural and ethnic matching may facilitate this to a greater or lesser extent in certain groups or individuals (Farsimadan, Draghi-Lorenz & Ellis 2007).

There are, however, few studies with actual clients currently in therapy: some studies ask participants to imagine their perceptions or responses, and others are archival in nature - the latter suggest that ethnic matching reduces dropout and enhances positive outcomes, but does not touch upon the therapeutic alliance or similar issues (Farsimadan,

Draghi-Lorenz & Ellis 2007). This study aims to examine whether ethnic matches mediate the effect of process variables on therapeutic outcomes and perceptions, in real therapist-client dyads (Farsimadan, Draghi-Lorenz & Ellis 2007). The effectiveness of the therapist and the working alliance were measured, as were measures on a global scale of symptom severity. This research does not take into account or investigate the effects of socioeconomic status, previous experience of therapy, education level, and presenting problem on therapeutic outcome and perception, and they have previously been shown to interact with ethnicity to do so (Farsimadan, Draghi-Lorenz & Ellis 2007). Nevertheless, findings indicate positive outcomes in matched dyads. Furthermore, matching increased perceived credibility of the therapist (Farsimadan, Draghi-Lorenz & Ellis 2007).

How does ethnically matching the therapist and client affect therapeutic process and outcome (Farsimadan, Khan & Draghi-Lorenz 2011)? Much research has now been done on this topic; after a slow start in the 1940s, interest in and, with the increasing mobility of the world, perhaps an increasing *need* for, knowledge in this area has led to a rise in such work (Christodoulidi & Lago 2010; Farsimadan, Khan & Draghi-Lorenz 2011).

Evidence from meta-analyses and reviews appears contradictory: some reviews have found that neither process variables (client self-disclosure, preference for therapist ethnicity and the perceived credibility of the therapist) nor outcome variables (drop-out rates, length of treatment, client satisfaction and willingness to return) are affected by ethnic matching (e.g., Sattler, 1977); some report an equal distribution of results between studies that report an effect and those that do not (e.g., Atkinson, 1985); and some reviews conclude that at least some ethnic groups appear to benefit from culturally sensitive therapy (Sue et al., 1994). It has been suggested that, on balance, all 'other things being equal, ethnic similarity may reduce the social distance and enhance the likelihood of shared beliefs and experiences between client and therapist, thus facilitating the therapeutic alliance and outcome' (Gray-Little & Kaplan, 2000). The methodological strength of studies has been challenged, bringing into question whether the conclusions drawn are in fact viable, or indeed even viable (Karlsson, 2005). Nevertheless, it is true

that such research is probably subject to similar methodological flaws as research into other psychological processes (Farsimadan, Khan & Draghi-Lorenz 2011).

Community-based approaches to therapy adaptation may be powerful tools for cultural understanding, because they involve not only therapists and clients, but also community stakeholders and collaborators. A few studies have been published that have proposed frameworks and recommended sequences for developing culturally adapted interventions. For instance, in discussing parenting training, Lau (2006) recommended an evidence-based approach that (a) prioritises selectively targeting problems and identifying communities that would benefit from them and (b) uses direct data outcomes to justify adaptations. In their commentary on Lau's (2006) work, Barrera, Castro and Steiker (2011) describe a sequence involving (a) information gathering, (b) preliminary adaptation design, (c) preliminary testing of the adapted treatment, and (d) adaptation refinement was recommended, which is similar to the model now be presented.

Domenech-Rodriguez and Wieling (2005) proposed a Cultural Adaptation Process Model, consisting of three phases: (a) the first phase focuses on the iterative process is based on achieving a decision or anticipated result after constant process among all those involved in the adaptation process (b) The second phase focuses on the selection and adaptation of evaluation measures and on the continual exchange between the community and those creating the adaptations, and (c) the third phase focuses on integrating the observations and data gathered in phase two in the creation of a new intervention.

This model of culture-based psychotherapeutic approaches provided by Domenech-Rodriguez and Wieling (2005) argue that community-based approaches lead to better ecological validity<sup>3</sup> by escalating community participation. Nicolas et al. (2009) provide an additional example of a community-based cultural adaptation model. Their model is based on work with Haitian adolescents. The authors outline the specific steps that can be taken to build collaborative relationships with the community, as a way to adapt the community-based approaches in a culturally responsive manner.

A book on culturally responsive CBT with different groups has also been published (Hays & Iwamasa, 2006). Hays (2009) provide a more recent discussion of the integration of CBT with multi-cultural therapies, demonstrating the efficacy of such an integration in psychotherapy.

The findings of Smith, Rodrigues and Bernal (2011) and others (Comas-Diaz 2006; Gone 2010) are directly relevant to this research. They provide support for the underlying contention that psychotherapeutic modules tailored to specific ethnic communities are more effective.

### ***3.15 Theoretically Developed Radical Models of Psychotherapy***

In addition to the above two approaches, there is another opinion amongst scholars (e.g., Hall, Hong, Zane & Meyer 2011). They argue that traditional psychotherapeutic approaches need to be discarded and replaced by ethnically relevant and meaningful techniques. For instance, they cite ‘mindfulness’ and ‘acceptance-based’

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<sup>3</sup> Ecological validity usually refers to the association between phenomena of real world and the assessment of these phenomena in tentative milieu (Schmuckler, 2001).



techniques for Asian clients. The reason to cite this recommendation is that techniques such as 'mindfulness' are similar to traditional mental health treatments followed by a number of Eastern communities. Hence, members of Asian communities might feel more comfortable and engaged with culturally relevant methodologies.

Hall et al. (2011) also propose that effective cultural therapy must include a proactive approach to acknowledging and then dissipating stereotypes as well as prejudices. In addition, there is a need to accept the role played by cultural differences in client-therapist communication, as well as in the formation of a therapeutic alliance. Furthermore, cultural differences are important in client motivation and engagement (Hall et al. 2011).

There is a tradition in cross-cultural research of using nations as units of analysis (Minkov & Hofstede 2012). However, there are dissenting opinions on the concept of national culture itself, based on the argument that may be significant variability *within* cultures, and striking commonalities across cultures; arguably rendering the concept of national or cultural identity useless (Minkov & Hofstede 2012) and perhaps even dangerous when conclusions are used to inform our understandings, sentiment and even policies on cultural or national matters. These controversial arguments, however, lack empirical support, and many notable political scientists and economists maintain that national culture is a sound concept: 'Despite globalization, the nation remains a key unit of shared experience and its educational and cultural institutions shape the values of almost everyone in that society' (Inglehart & Baker, 2000, p. 37). Parker (1997) argues that national culture determines, to a large extent, the economic development, demographic behaviour and business trends of countries. Nevertheless, dissenting opinions arise given the fact that many nations encompass diverse sub-cultures (for example, the Balkan gypsies (Roma, Sinti, Manush and Egyptians) throughout the peninsula); because this has even led to the disintegration of nations in some cases,

various authors argue that the concept of a nation might not in reality bind a country as decisively as once believed (Boyacigillar, Kleinberg, Philips, & Sackman, 2007). The meaningfulness of the concept itself is widely challenged (e.g., Baskerville, 2003).

Some research has been carried out on cultural differences between in-country regions, but their collective findings are inconclusive. Examples include studies on Flemish Belgium and the Netherlands, which were clearly distinguishable on cultural indicators despite a common language; and closer similarities between Swiss-Germans and Germans than between the Swiss-Germans and Swiss-French (Hofstede, 1980, 2001). Teachers and university students in Shanghai in northeastern China and Guangzhou in southern China differed more on cultural values from each other than Japan did as a nation from the US (Schwartz 2006). Various Nigerian ethnic groups were found to differ significantly on some cultural indicators but be indistinguishable on others (Peterson, Fanimokun, Mogaji & Smith, 2006 in Minkov & Hofstede 2012). This last study illustrates the crux of the issue: that cultural values and indices in themselves are homogenous, making research into such issues all the more complex, as it is not possible simply to conclude that a nation or in-region culture is clustered on *all* cultural variables (Minkov & Hofstede 2012).

Minkov and Hofstede (2012) examined basic cultural values along national lines in order to investigate this hypothesis; the aim was to determine whether, if in-country regions are compared on cultural traits, national boundaries largely dissolve—this would have significant implications for the ways in which the concept of and research on nations is comprehended, conceptualised and conducted. Findings indicated that '299 in-country regions from 28 countries in East and Southeast Asia, sub-Saharan Africa, Latin America and the Anglo world overwhelmingly cluster along national lines on basic cultural values, cross-border intermixtures being relatively rare' (Minkov & Hofstede 2012, p. 133). Even countries that might intuitively appear culturally homogenous, owing to their shared languages, religions, history, traditions and ethnicity (for example, Malaysia and Indonesia, Mexico and Guatemala, and neighbouring African nations such as Ghana and

Burkina Faso) demonstrate clear clustering on their own cultural values (Minkov & Hofstede 2012).

Inglehart (2006) notes that '[t]he world now contains nearly 200 independent countries, and the beliefs and values of their publics differ greatly, in thousands of different ways' (p. 115).

Cross-cultural variation may be conceptualised according to two dimensions: the traditional/secular-rational dimension represents the disparity between the traditional, religious values of agrarian societies and the bureaucratic, rational, secular values that characterise industrialised, urban societies; and the survival/self-expression dimension encompasses a wide variety of beliefs and values, and represents the shift from a focus on economic and physical survival and security towards an emphasis on subjective well being, self-expression and quality of life (Inglehart 2006). These dimensions are reliable, valid cross-cultural indices and allow the position of a society to be mapped according to its shifting positions in relation to these two dimensions (Inglehart 2006).

Cultural change and the manner in which cultures are conceptualised cannot be discussed today outside the context of modernisation: Industrialisation and modernisation has not, as predicted, been exclusive to the West, has not been linear, and has not led to the demise of religion, as predicted by, for example, Marx and Weber (Inglehart 2006). Industrialisation has and continually does, however, effect social and cultural change; including, for example, better education and transformation of gender roles; thus including the values and beliefs of the people: 'economic development is associated with predictable changes away from absolute norms and values, towards a syndrome of increasingly rational, tolerant, trusting, and post-industrial values. But we find evidence of both massive cultural change *and* the persistence of traditional values' (Inglehart 2006, p. 116). Changes in economics, politics and sexual life follow from cultural change and the ability to focus on self-expression over survival (Inglehart 2006), while at the same time representing a source of stress, as individuals are distanced from their culture (Ward,

Bochner & Furnham 2001). In the context of the current study, this is readily observable: those immigrating from Iran to the UK have somehow to adapt to their new culture. There are various ways of doing so, the way an individual adjusts is influenced by various factors, including age (Farsimadan 2011).

Although traditional versus rationale and survival versus self-expression values are immensely robust and reliably occur in polarity to each other, and although human values show a strikingly coherent structure according to world value surveys, economic development interacts with a society's cultural heritage and therefore distinct cultural zones have emerged, evolved, and persist today (Inglehart 2006). Thus the same kind of economic developmental forces exert different kinds of pressure of various cultures, which respond accordingly, leading to an immense variety of different cultures (Inglehart 2006). All 11 Latin American societies in the world, for example, cluster coherently around similar values, and more strongly emphasise self-expression than their economic context would lead researchers to anticipate (Inglehart 2006). Religious and colonial heritage have an abiding effect on the cultural character of countries. Illustrative examples demonstrate that, even when economic development is controlled for, the Communist rule of countries with this political history, for example, accounts for cross-cultural variance in cultural values (Inglehart 2006); an Orthodox heritage reduces self-expression values (Inglehart & Baker, 2000).

Survival versus self-expression or individualism is of broad interest in the field of psychological research (Minkov & Hofstede 2012; Inglehart 2006; Inglehart & Baker 2000; Inglehart & Weltzel 2005). Individualism refers to an emphasis on rights over duties, concern for oneself and immediate family, personal autonomy and self-fulfillment and founding identity upon personal accomplishments (Hofstede, 1980). Individualism vs collectivism or autonomy vs embeddedness have long occupied psychologists and represented a significant pin upon which personality turns (Inglehart 2006). These concepts are related not only to personality or personal development of each individual human but, more broadly, to humanity at large, since it ultimately is a shift in perspective

that reduced constraints on human choice (Inglehart & Welzel, 2005), rather than the traditional focus on the group - on society.

It may be argued that Hall et al (2011) have rendered psychotherapy too individualised and thus impractical to implement, since differences within groups-even amongst individuals who share ethnic and cultural backgrounds-are vast. This is an appropriate point at which to remark that psychotherapy may, ultimately, be regarded as inherently individual, since each lived experience, regardless of shared groups or cultures, is unique. This is important to keep in mind in the context of the current research. What we aim for here is a therapy more appropriate to those who have immigrated from Iran to the UK, but this is not intended to overhaul the well established therapeutic approach in itself- that is, the underlying tenets of engaging with another human being in a way that is helpful, supportive and enlightening-but rather simply to be awake to the possibility of cultural issues having an impact on the ways in which they process or understand their own situation and how this impacts upon the therapeutic situation (and vice versa) in terms of their working through difficulties and engaging with the therapist.

The recommendations of Hall et al. (2011) fall short of the brazen, radical approach proposed by Wittkower and Warnes (1974). These scholars recommended a set of guidelines to the Western psychotherapist dealing with culturally-diverse clients. According to these scholars, these guidelines can be used when working with culturally-diverse clients in the interim and till the point in future when they become more 'Westernized'. These guidelines include a recommendation for the Western therapist to obtain skills that can help him or her in overcoming the suspicion of their culturally-diverse clients, thus gaining their trust. A suggestion is to collaborate with culturally respected traditional healers such as community priests, and in some cases, even witch doctors, hakims or shamans (Wittkower and Warnes 1974). The authors suggested

integrating these folk healing methodologies into psychotherapy, thus tempering Western psychotherapy using cultural sensitivity for culturally-diverse clients (Wittkower and Warnes 1974).

### ***3.16 Synthesised Framework for a Culturally Competent Psychotherapy Programme***

The researchers own adaptation of some of the aforementioned ideas is now presented, constituting the central part of this thesis. Based on the frameworks and literature reviewed, it is evident that a synthesised framework for a culturally competent psychotherapy programme needs to be developed. This synthesised framework is the Multi-cultural Adaptation Framework. It is based on the Cultural Adaptation model, on the Clinical Multi-cultural Reality Therapy and on the literature, which suggests that the region to which an individual belongs does not necessarily define culture.

The justification for this synthesised framework is that it allows more focus and power to be invested in the therapist rather than the client, with the objective of making decisions on culture-based interventions. The nature of the therapeutic relationship means that the therapist is inherently invested with power, simply by virtue of their role as someone the client approaches for assistance. In PEP, this structure is adhered to, since, although the client will be making decisions on the cultural perspective from which he wishes to be treated, the therapist need not also be from this background. According to this proposed model, the therapist should possess the professional competency to work in accordance with the cultural perspective requested by the client; the classical therapist-client dynamic will, nevertheless be retained.

The suggested framework will also address the debate that whether Western psychotherapy is needed for the UK or whether cultural psychotherapy is preferable. The debate concerns the question of what the client wants to achieve, and whether the therapist is in a position to help them do this. This framework's practical application involves a three-tier approach, namely, to identify, adapt and change.

At the identification phase, the therapist and the client will identify the cultural perspectives desired by the clients to be used for the session collaboratively. Once the therapist can guarantee professional competence for this approach, the next phase enables adaptation of the cultural perspective by the client, by identifying all possible implications of the intervention. Following effective accomplishment of this task, the final phase involves the use of clinical interventions to gather data on a client's problem and provide suitable solutions.

## **CHAPTER 4: PEP (PSYCHO-EDUCATIONAL PSYCHOTHERAPY PROGRAMME)**

### ***4.1 Introduction***

The existing Psycho-Educational Psychotherapy (PEP) programme was based on professional psychotherapeutic experience, and on research with Iranian clients and with therapists who see Iranian clients. The aim of this thesis is to use the PEP programme as a framework, and to develop it, making it better informed, more legitimate and applicable, most importantly, better able to provide effective psychotherapy for Iranian couples who have immigrated to the UK.

The thoughts, rationale and decisions that structured the programme are presented here, as these are important tenets of the final, improved programme to emerge from this study.

### ***4.2 Programme PEP: Psycho-Educational Psychotherapy Programme***

The PEP programme was initiated while the researcher was working at the NHS. Whilst working at FPEP and MEFSE, weekly seminars were offered to all clients. Attendees were enthusiastic about the seminars and I realised that Middle Eastern clients might require more prolonged, intensive psychotherapy, possibly in a group setting. I realised that introducing a seminar as a regular component of a psychotherapy programme might be useful.

As discussed, my 15 years of experience working with Middle Eastern culture, specifically with Iranians, including developing services such as the MEFCE and FPEP and observing all outcomes with a wide range of clients, led to the creation of PEP



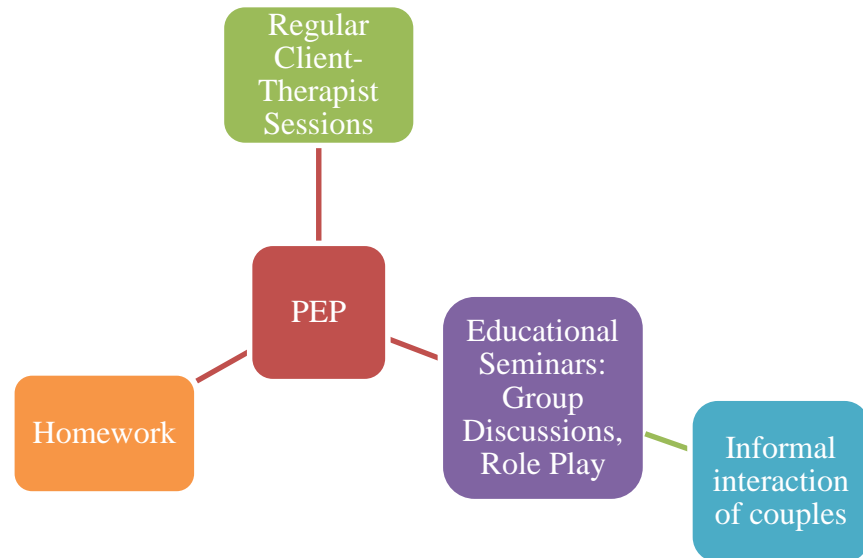
(Psycho-Educational Programme). By working with, researching and interviewing my colleagues, I became increasingly certain of the expectations of Iranian clients in therapy, and of their desire and need for long-term, intensive therapy. Intensive therapy refers to providing more facilities than only weekly therapy sessions (individual, couple and group therapy) plus support for social activities and family lives outside the seminars. Through years of trial and error, and feedback from both therapists and clients, it became clear that an intensive approach such as this allowed clients to engage more with one another and with the therapist, and to learn more from one another's experiences. It was found that, by increasing the intensity of the therapy—that is, by incorporating features such as weekly seminars and workshops into the program—the following therapeutic benefits are maximised: breaking taboos, such as the fear of facing each other in the group, or of talking frankly in front of other members; listening to the stories of other member and issues, which assists in understanding others and in drawing parallels with one's own issues; stopping self-victimisation; expressing themselves through drama therapy; learning about psychology; educating and learning more in depth on psychology, sociology and others; understanding differences and accepting other; respecting themselves and each other's; trusting and learning to trust others; engaging themselves with homework in the private facebook (just for the seminar's member); building their self-esteem and confidence. By having this kind of service we can engage them more for long-term and intensive therapy, give them a new kind of life style which they couldn't have in their new societies. Older generations of immigrants feel lost and cannot engage with the new generation; this leads to higher levels of conflict for them in the family and between couples.

Later, when the researcher started her private practice, a structure of psychotherapy that included regular client-therapist sessions, seminars and homework was introduced (see Figure 2).

One-on-one sessions with couples are integral to PEP. Certain assumptions and insights about the perceptions and attitudes of Iranian clients toward psychotherapy were also used in structuring the one-on-one sessions.

Homework was also incorporated, despite the knowledge that Iranians may dislike the notion. Iran's educational system is based on rote learning and students spend hours completing homework assignments. Homework thus has negative connotations for this population. However, it was still thought that encouraging people to commit to doing something between sessions would help them assume responsibility for their mental health. Clients decided whether or not they want to do the homework, guided by the therapist. Homework includes a variety of activities. Clients may submit their homework via a private Facebook group, and discuss what they have learnt each week.

### 4.3 The Multidimensional Structure of PEP



**Figure 2: PEP as a multi-dimensional programme comprising of three basic components**

PEP begins with clients approaching for one-on-one sessions. The initial aim is to establish legitimacy for the clients' need to seek psychotherapy. Iranian culture is collectivist: family matters are usually solved by relatives and friends (Kautlaki 2010). People are not encouraged to seek professional therapy to solve personal problems. Iranian couples living in the UK may not have access to their extended family for support; they may feel isolated and lost. Further, the fear of being judged by the community, and of not being understood by a Western therapist, is a concern. Iranian men, especially, are afraid of 'losing face' in front of others, even strangers (Kautlaki 2010). This is perhaps linked to the patriarchal system of Iran, in which men (particularly Eastern men) are presumed and expected to be self-sufficient, and in which seeking help is taboo. Female Iranian clients tend to avoid psychotherapy owing to a reluctance to discuss sexual issues in front of their husbands. Some prefer female psychotherapists,

knowing that they may be more familiar with the challenges they face. Katouzian (2010) notes that in the predominantly orthodox Muslim culture, there is a strict separation of sexes and any discussion of sex-related topics is discouraged. Davy and Cross (2004) acknowledge that 'these culturally learned, cultural inhibitions operate when the clients hesitate to discuss their sexual problems with the therapists' (p. 169). Ultimately, because of the lack of trust common in clients at the outset of this process—and because of their not knowing about the concept of therapy—the purpose of the initial PEP sessions is to *normalise* therapy for these clients. By discussing the purpose of therapy and the form it may take—by setting the therapy in context and making sure clients feel safe to discuss such issues—I aim to encourage them to believe that receiving psychotherapy is okay.

The task of the next few sessions is to encourage the client to start talking about his or her issues. The 11Cs Assessment was developed for this purpose—to open dialogue for such discussions—and is initiated when clients demonstrate acceptance of having a problem that needs to be solved. The researcher heard about an assessment known as the 7C's from a clinical psychologist colleague in Iran (N Farnoody, 2000, pers. comm., day month). This was used as a foundation, to which another four conditions, which the researcher considered important based upon her own clinical experience, were added. It is acknowledged that this assessment has not been systematically, empirically developed, and so such lacks validity, reliability and generalisability. It is employed here as a qualitative clinical assessment for the purposes of therapeutic work.

When completing the 11C's Assessment, Spouses are given a list of parameters according to which to rate their relationship:

Criterion	Rating									
Chemistry	1	2	3	4	5	6	7	8	9	10
Culture	1	2	3	4	5	6	7	8	9	10
Communication	1	2	3	4	5	6	7	8	9	10
Controlling	10	9	8	7	6	5	4	3	2	1
Character	1	2	3	4	5	6	7	8	9	10
Capacity	1	2	3	4	5	6	7	8	9	10
Conflict resolution styles	1	2	3	4	5	6	7	8	9	10
Co-operative	1	2	3	4	5	6	7	8	9	10
Commitment	1	2	3	4	5	6	7	8	9	10
Compromising	1	2	3	4	5	6	7	8	9	10
Compatibility	1	2	3	4	5	6	7	8	9	10

**Table 1: 11Cs Assessment rating Criterion**

The completed scale is kept private until later sessions. At this point, clients are invited to participate in weekly seminars. The aim of the seminars is to show them that other people like them are talking openly about their issues, and that there is nothing wrong with doing so.

An atmosphere of trust continues to be created during the sessions, so that clients become more comfortable talking about their problems.

In most cases, several individual sessions are conducted with each partner, during which they may talk openly about their problems. During these sessions, clients are asked to explain factors that have encouraged them to attend therapy, as well as their expectations of the sessions. The therapist ends sessions by recapitulating the issues as she understands them.

The next few sessions involve the beginning of couple's therapy. Iranians have an inherent tendency to respect authority figures and to expect guidance and leadership from them. Samovar, Porter and McDaniel (2009) argue that 'manifestations of high power distance in Iran can be observed in the significance of the roles played by various authority figures in Iranian culture. For instance, parents, elders, teachers, and the clergy play a very important part in the formulation of decisions such as marriage, buying a house, and choosing a profession or a field of education' (p. 180).

This attitude may result in Iranian clients expecting that the therapist, as the professional, can provide solutions and 'fix' their problems. It is thus explained that the therapist will assist the clients in their healing process, by helping them obtain better insight into their problems and their underlying causes, including entrenched cultural and psychosocial factors.

When clients are ready to engage and participate in the therapeutic process, they are invited to attend the weekly weekend seminars on a regular basis. Attendance is not compulsory, but is strongly recommended. The seminars offer an interactive therapeutic experience, during which clients not only witness other people having similar problems, but can also actively participate in group discussion and role play. When clients see other couples and families talking about similar problems, they can vicariously speak out about them too, without retreating from their comfort zones. The most effective part of the seminars involves the role plays. This includes aspects of drama therapy, which helps clients explore and express their feelings. Barak (2013), Landreth (2012) and others find

persuasive evidence to support the use of narrative<sup>4</sup> and role play as therapeutic tools. Enacting real-life situations with role play can help clients articulate thoughts and feelings.

Each seminar focuses on one issue, including arranged marriages and lack of understanding between couples; marriages made only to gain UK citizenship, with consequent lack of bonding between couples; Iranian men wanting to exercise power and control in marriage, with women wanting freedom; lack of openness regarding sexual issues; issues with in-laws and extended family; rekindling relationships; achieving emotionally healthy divorces; abusive or toxic relationships; cultural conflicts, irrational fears and marital stress. In addition to participating in the seminars, clients are encouraged to get to know the other participants, to engage in conversation, and to become friends. Unlike other UK Asian immigrants who are comfortable interacting with their own community members, Iranian immigrants are reluctant to form relationships with fellow UK Iranians, causing alienation and isolation. It is important for the mental health of couples that they get to know other couples from Iran, who may have similar problems. Clients are persuaded to interact and meet outside therapy. Informal interaction is expected to provide couples social support and a sense of belonging, which may positively impact their relationship. Usually, group therapy places restrictions on group members meeting outside the group. In the present case, because Iranian immigrants tend to have less active social lives, this was overlooked in order to foster socialisation. The

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<sup>4</sup> It utilises story-telling/writing activities as scientific investigation instruments and deals with the construct of obtaining meaning from the experiences of individuals (Cihodariu, 2012).

programme has a confidentiality contract, and meeting weekly enables clients to resolve conflicts as they get to know each other better. If difficulties arise, clients are encouraged to discuss these with one another and with the psychotherapist.

It is imperative to note at this point that ethnic matching does not necessarily directly translate into clients' feeling safe within the therapeutic setting, an argument well explicated by Nguyen (2014). Increasingly diverse societies mean more interactions with people, on both a personal and professional level, who do not share our cultural, ethnic, social and linguistic background. Language gaps may be considered of especial interest in the relationship between therapist and client who are engaging in what is known as 'talking therapy'. It was reported in this study that, when confronted with a therapist from another culture, some monolingual clients made certain assumptions—for example, that they needed to try harder to connect with the therapist—and some felt that they would be more accepted, because the therapist themselves represented a departure from those in society they might have felt generally judged by. Bilingual clients perceived this as a common bond they had with their therapist, and that it sometimes led to idealisation and unrealistic expectations that they would understand more easily. Being culturally, ethnically and linguistically matched sometimes led to concerns around confidentiality, as such immigrant communities in certain areas may be small. The study demonstrates that it is difficult if not impossible to separate language from culture. Identification and over-identification were discussed as issues with cultural and linguistic matching - expectations regarding the other being able to identify with one's feelings and needs, and may lead to a delay in the client achieving independence and individuation, in the same way that an infant in early development may be delayed by overidentification with its parents. Some researchers report the benefits of shared culture and language, in its leading to more productive work (e.g., Verdinelli & Biever, 2009); on the other hand, over-familiarity might lead to the premature ending of therapy (e.g., Antinucci, 2004 in Nguyen 2004). These considerations were kept in mind throughout the current study, and



suitable self-reflection was employed in order to maintain the integrity of the therapeutic relationship, whilst aiming to allow for cross-cultural intersection.

On the practical side of the programme, homework is essential: clients are encouraged to keep a journal of reflections on the therapeutic process or on changing perceptions of one's spouse.

The sessions, in combination with the seminars, help clients understand more about the underpinnings of functional behaviour and positive attitude. CBT is employed to alter negative thoughts, feelings, and behaviours and to help clients adopt positivity. They are asked to practice different behaviours towards each other for the next week. They are also expected to report back on their behaviour, what reaction their spouse had to their behaviour, and to talk overall about their perceptions on their relationship at that point.

Once clients have attended six seminar sessions, they are encouraged once again to talk about their individual perceptions of the root causes of their problems, and compared to previous perceptions. They are motivated to talk about changes they have experienced in their attitudes and how they intend to change their behaviour towards each other, and can create a plan of action for themselves.

In the final sessions, the progress that has been made in communication and acceptance between the clients is usually discussed. Future goals and pathways are set to ensure the continuation of open communication between spouses.

The research methods discussed below were used to modify this culture-based therapy programme, by comparing interview results and generating themes that add to the existing psychotherapy programme.

#### ***4.4. Research Design***

Interviewing therapists who have worked with Iranian clients was the most comprehensive method of study to provide high validity<sup>5</sup> that would thus strongly argue for the need of culture-based therapy, particularly in the ways it is relevant to UK Iranians. The suitability of the choice of interview was based on various parameters. It was related to the attempt to probe the therapists' experiences deeply. To do this, the method had to be intensive, i.e. in-depth interview. It also had to begin with the analysis of observations and lead towards notions and generalisations, to provide enhanced assistance in understanding the problems faced by Iranian immigrants. Finally, the interview would need to be flexible to allow for a variety of data.

Interviews are a suitable way to obtain information about therapists' experiences. Aaron (2012) used semi-structured interviews to explore the experiences of therapists during clinical practice. He states that interviews provide the opportunity of engagement and reflection on experiences of the therapists, and also allow a detailed presentation of the experiences and most sensible manner to elicit accounts of the psychotherapists. A researcher can prompt the interviewee to obtain more information. The advantage of using interviews is that it is more personal—the researcher can work directly with the

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<sup>5</sup> Validity is the extent to which a test measures what it has been intended to measure or the degree to which theories and tests supports the interpretations (Drost 2011).

interviewee. However, this method requires many resources and is time consuming. The present research used the general interview guide approach to provide focus on general areas of information. This approach is more structured in contrast to the informal conversational interview. Wording of questions in this approach depends on the researcher conducting the interview. The strength of this approach is in the ability of the researcher to collect the same general areas of information from each interviewee to provide more focus in contrast to the conversational approach (Turner 2010).

#### ***4.5. Primary research***

A pilot study was undertaken as part of this project. It explored the responses of therapists with regards to the idea of culture-based psychotherapy as applied to UK Iranian immigrants. The research provided useful insight into the manner in which experienced therapists respond to challenges faced by immigrants in the UK and the impact of these challenges on psychotherapy. 15 psychotherapists were interviewed.

In terms of ethics, it was made certain that all participants consented to the interview (through a signed agreement). They were assured of confidentiality, which was also confirmed with signed documents. As part of the research, my own experience of the researcher as a psychotherapist in the UK was also used. The researcher has worked with Iranian clients, and has held seminars and workshops, at which clients shared their challenges as immigrants and explored the kind of therapy they preferred with the objective of providing them with better help with their issues.

## CHAPTER 5: RESEARCH APPROACH, EPISTEMOLOGY, AND PHILOSOPHY

### ***5.1 Introduction***

This chapter discusses the research philosophy that underpins the data collection and analysis used in the current research project.

### ***5.2 Research Approach***

An exploratory research model was used for this research. New subject material was explored, leading to the investigation of a research area that has not yet been charted by other scholars. As the literature review highlighted, there are a number of studies focusing on cultural therapies. However, barely any of them have focused on cultural therapy as specifically applied to Iranian immigrant communities in the UK. It is for this reason that current study takes an exploratory stance, which is conducive for research aiming to establish new information or explore novel concepts (Finlay 2009). Exploratory research provides a substantial degree of flexibility, allowing the use of diverse methods of data collection so that information can be collected from a variety of sources (Smith, Flowers & Larkin 2009).

### ***5.3 Research Epistemology and Philosophy***

This research takes a constructionist epistemological view, implying that constructions (concepts, knowledge, or insight) are not absolute or objective, but is subjective and context-dependent (Creswell 2007). This stance also indicates that reality is not something objective that can be discovered; it is something subjective that is

actively constructed by the people involved. Moreover, reality is seen as a social construct rather than a personal or individual construct. This suggests that reality is subjectively viewed in the context of particular social settings (Smith, Flowers & Larkin 2009).

Epistemology deals with the study of forms, limits, sources, and nature of knowledge (Dretske 2008). Social constructionism is defined as a viewpoint that believes in the existence of human life based on interpersonal and social influences. It considers individuals as inextricable from the historical, political and cultural evolution of particular instances and places, and consequently re-situates psychological processes cross-culturally, in temporal and cultural contexts (Owen 1995). This has emerged as a strong perspective in the social sciences and has become predominant in some areas. In contrast to positivism, it is socially constructed. It has often been connected with postmodernism, which, though similar in many respects, differs in its essential characteristics (Burr, 2003).

Within the overarching framework of qualitative research, various methodological paradigms exist, including positivism, constructivism, naturalism and postmodernism (Seale, 1999). These are all variously defined and implemented, and ultimately represent overlapping methods for coming into contact with qualitative material, or for managing this coming into contact. When appraising one's methodological approach or paradigm, it is important to remain mindful that qualitative research is a skill, a craft or an art, relatively independent of philosophical paradigms or inquiry, or the need neatly to categorise these separately and cleanly (Seale, 1999). Positivism and constructivism both 'critically analyze the degree to which traditional western counseling theories and interventions fail to account for the ways that different cultural traditions, values, beliefs, and worldviews affect clients' constructions of their intrapersonal and interpersonal experiences' (D'Andrea 2000). Both paradigms prioritise developing intervention strategies that take account of multicultural and ethnic concerns, in order to treat and

engage with ethnically diverse groups effectively; they also both acknowledge the potential harm of treating such patients with a purely traditional modern counseling approach (D'Andrea 2000; Farsimadan 2011). In my opinion, the greatest distinguishing feature of postmodernism as opposed to constructivism, is that the fundamental task of the former is to encourage a kind of relativistic thinking by acknowledging that we must inhabit various and sometimes conflicting identities in our postmodern world—it primarily involves a systematic breakdown of preconceived notions (D'Andrea 2000). These may include religious and scientific conventions; indeed, any absolute truths we have come to accept unquestioningly (D'Andrea 2000). In the current study, this would naturally extend to beliefs about ultimate truths to do with culture, ethnicity, sexuality, nationality, etcetera. Constructivism, by contrast, places a greater emphasis on the build up than the break down: on clients actively engaging in structuring and creating their experiences, imbuing them with one's own significance and meaning. Although highly similar and in service of the same kind of research, the former ultimately has to do with deconstruction; the latter with construction.

Many researchers have found the subjective and contextual interpretation of reality useful (e.g., Finlay 2009; Smith, Flowers & Larkin 2009). Constructionist epistemology is applicable to this research, as it aims to explore a subjective situation that deals with the manner in which people from a culturally-diverse community understand and experience psychotherapy.

At the same time, a phenomenological approach has also been taken, which is found to be compatible with an exploratory and constructionist view (Finlay 2009). Phenomenology deals with the illumination of the specific, with identifying phenomena in the manner in which the actors in a circumstance perceive them. It is related with the study of experiences from the perspectives of the individual (Lester 1999). The phenomenological stance enables obtaining information from respondents (who are

directly involved with the research topic) from their particular point of view (Neuman 2005). It can aid in producing enriched contextual data that helps in understanding the situation from the participants' perception. The phenomenological approach is useful as the aim of the research is to explore the thoughts and opinions of the participants, who are either experts in the field or otherwise have some qualities suggesting that they have suitable knowledge for this study.

As this research focuses on the insights of psychotherapists directly involved with the immigrant Iranian community, a phenomenological approach is useful to better present their perceptions. One disadvantage of phenomenological research is associated with the subjective nature of data collection and analysis that might lead to inaccuracies or misinterpretation of research findings. A positivistic approach, on the other hand, may have yielded more objective and accurate results. Positivism refers to knowledge gained from the positive verification of experiences that may be observed rather than, for instance, intuition or introspection. It relies widely on manipulative and experimental methods to ensure a distance between the objective realities observed by the researcher and his subjective biases (Cohen & Crabtree 2006). This was the consideration that initially resulted in consideration of this approach for conducting this study. The researcher wanted to use a mixed-method approach, involving a positivistic component. It was found that the positivistic approach could yield data that would be more amenable to scientific and statistical interpretation. Moreover, it could help in studying a large amount of quantifiable data that could be statistically interpreted to showcase the results in simpler, more objective terms. However, the positivist and social constructivist

approach cannot co-exist as the social constructivist approach criticises the positivist approach.

However, it was also believed that a positivistic approach would be restrictive, as the perceptions of the target respondents, their inherent beliefs, and as yet uncharted opinions could end up remaining unexplored. Therefore, the idea of using a mixed-method approach based on positivist construct was discarded as it came to understanding of the researcher that a phenomenological stance would yield all the contextual data needed for this research. Moreover, a positivist construct would otherwise have resulted in keeping the researcher at a distance from the clients and not being involved with them (Cohen & Crabtree 2006).

The social constructivist approach has been applied in this research based on the PEP programme. The PEP approaches differ from that of other psychotherapeutic approaches. The factors demonstrating these disparities in these approaches are presented in the table below:



<b>Iranian Clients' Expectations</b>	<b>CBT (Crane, 2008)</b>	<b>Person-centred Approach</b>	<b>PEP (Psycho Educational Programme)</b>
The therapist is a figure of authority	Therapist as facilitator	Therapist as facilitator	Therapist as a guide and leader initially, then empowers the client
Want quick-fix solutions and no involvement in therapy	Client needs to be involved intimately in a pre-structured programme	Client needs to be involved intimately in a pre-structured programme	Present an engaging programme that draws in clients
Hesitant to talk about personal/sexual issues	Does not include actively prompting the clients	Does not include actively prompting the clients	Therapist actively talks about the issues and lets the client know that he/she will listen without causing embarrassment.
Fear of being judged by the therapist	The therapist does not ease the client's fear	The therapist does not expressively ease the client's fear	Therapist pro-actively talks of his or her own background and declares a stance of non-subjectivity
No faith in Western therapists' ability to	Therapists not required to put the	Therapists not required to put the	Therapist lets the clients know that

understand their specific issues	clients at ease about their understanding of cultural implications	clients at ease about their understanding of the cultural implications	he/she understands their background.
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**Table 2: Difference between PEP and other approaches****5.4 Participant details**

Name	Age	Gender	Ethnicity	Organisation	Therapeutic Orientation/Experience
R	46	M	French/Algerian	NHS private practice	Senior CBT
S	63	F	English	NHS	Senior Counsellor/couple therapist
G	59	F	Iranian	Each/private practice	Senior CBT/Family therapist
L	54	F	African	NHS	Counsellor/Couple therapist
A	47	M	Asian	Each/private practice	Senior Counsellor/Couple therapist

**Table 3: Detailed description of participants ensuring confidentiality of their names and other identifying details**

The next chapter presents the findings obtained during primary data collection. As described above, data was collected from a group of five psychotherapists. All of them have experience working with Middle Eastern clients, including Iranian couples. The aim

of data collection was to gain a better understanding of participants' attitudes in terms of the effectiveness of Western approaches when dealing with Iranian clients. Data was collected through the use of an interview guide, which is a more structured qualitative data collection tool compared to the informal conversational interview (Turner 2010). It included 19 open-ended questions related to the experiences of therapists with Iranian clients. Findings are discussed in the next chapter.

## **CHAPTER 6: RESEARCH DESIGN, SAMPLING, AND DATA COLLECTION**

This research project involved gathering information so that it could lead to the development of a specific intervention, namely (as discussed above), a psychotherapy programme to meet the needs of Iranian immigrants in the UK. This programme was based on PEP. Some details, in terms of the research design of this project are presented in this section: sampling, data collection, data analysis tools, and techniques that have been employed. Data was gathered from the psychotherapist's interviewees. An updated PEP was designed based on these responses.

### ***6.1 Research Design***

A flexible research design was adopted, as it was understood that this research was innovative. Thus, there was a need to modify the methods according to the needs that the research posed as it proceeded (Robson 2011).

A more rigid research design was initially considered owing to the more established 'sturdiness' that might have helped to keep the research 'on track' besides ensuring that the plan would be implemented in a timely, and accurate manner. However, due to the researcher's role as a psychotherapist, the importance of a more experiential and flexible approach to problem-solving was considered. It was believed that the research design for a study that aims to collect information from psychotherapists, in terms of their approach to work with Iranian couples, needed to be based on a more unstructured (or rather, semi-structured) model.

The semi-structured design adopted left a lot of scope for making flexible changes as and when needed. The research design reflected the true nature of the ‘real-world’ problems encountered in the work, in all their complexity that could not have been captured were a more rigidly structured research design used.

To reiterate, a flexible research design for this exploratory research was selected. In this approach, the aim was to assess the availability and effectiveness of culture-based psychotherapy programmes for UK Iranian couples. The design was based on a basic sequential activity programme that also allowed flexibility, in terms of shifting the activities back and forth in time. It facilitated changing activities altogether if that was perceived to be necessary as the research progressed.

The steps included:

1. Developing the research questions
2. Conducting a literature review and finalising the research questions
3. Drafting the literature review and PEP overview chapters
4. Drafting the methodology chapters through the development of an interview questionnaire, and a focus-group questionnaire
5. Sampling for the interviews
6. Scheduling and conducting interviews with psychotherapists
7. Incorporating insights from the psychotherapists’ interviews to PEP
8. Redrafting the methodology chapters and fine-tuning the interview questionnaire
9. Scheduling and conducting a pilot interview
10. Contacting some culture-based psychotherapy centres with interview requests

11. Drafting a results chapter, redrafting of the methodology chapters, fine-tuning the focus-group discussion questionnaire
12. Contacting the psychotherapists to arrange the focus-group discussions
13. Scheduling and conducting the first focus-group session
14. Drafting the results chapter; incorporating insights from the first session of the focus-group to PEP
15. Scheduling and conducting the second session of the focus-group
16. Drafting the conclusions chapter, revising the whole dissertation, and drafting the project's final presentation
17. Drafting the results chapter and the discussion chapter, incorporating insights from the second session of the focus-group to PEP

Initially, the an Internet search was planned, to identify psychotherapy centres in the UK. However, this was discarded after a discussion with academic advisor, who advised to attempt identifying such centres in a more sophisticated way. Therefore, the sampling plan was converted to include only those psychotherapy centres mentioned in BACP or UKCP journals<sup>6</sup>.

After finalising this selection, a letter of request was sent to the identified centres, to explore whether there would be an interest to participate in the research study. However, no response was received. It was decided to enlist the support of a friend and fellow counsellor (a friend who used to work in the NHS with the researcher); this counsellor helped identify some participants from a number of UK therapy centres.

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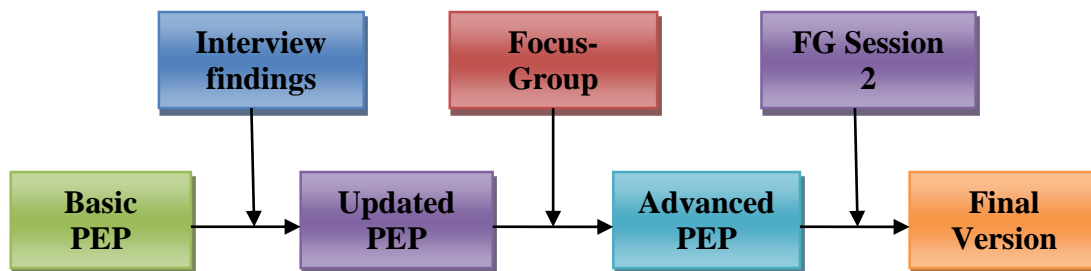
<sup>6</sup> BACP refers to the British Association of Counselling and Psychotherapy. UKCP refers to the organisation named UK Council for Psychotherapy.

## 6.2 Secondary Approach

Secondary research comprised development of an exhaustive literature review on topics of interest, namely, the availability and utility of culture-based psychotherapy programmes for couples from immigrant Iranian communities; specific issues faced by psychotherapists when dealing with clients from diverse cultures; and specific problems faced by immigrant communities, especially Iranians, in Western countries like the UK. To conduct the literature review, databases such as Pub Med, NCIMB, Ebsco, Emerald, and JSTOR, as well as Google Scholar, were used.

## 6.3 Primary Approach

Figure 3 presents a brief overview of research journey:



**Figure 3: Primary Research steps**

A detailed discussion of the research method is presented in the following sections.

### ***6.3.1 Part One: Interviews***

#### **6.3.1.1 Research Sample**

First, the availability of psychotherapy programmes in the UK for Middle Eastern clients, specifically UK Iranian couples, was explored. Therefore, this part of the research was aimed at gathering information from fifteen culture-based therapy centres in the UK that could be expected to have dealt with clients from the UK Iranian community.

Initially, it was important to obtain as many interviewees as possible. After an initial selection, fifteen therapy centres remained. The psychotherapy centres were selected from among a large number of culture-based psychotherapy centres that were found by using keywords such as ‘culture-based psychotherapy centres in the UK’, or ‘UK cultural psychotherapy’, or ‘Iranian Psychotherapy in UK’.

Thus, a list of centres remained that could potentially be used for this research. Some centres were also identified from the telephone directory. A list of fifty-one centres was compiled. Each of these centres was then contacted to assess their suitability for participation in the research. The criteria used for inclusion were:

1. Whether they dealt with culture-based psychotherapy for the Middle Eastern immigrant population, and more specifically whether they worked with clients from the Iranian community.
2. Whether each centre had, more specifically, offered therapy to Iranian couples in the past three to six months.
3. Whether each centre had psychotherapists with experience in couples therapy for immigrant populations, especially Iranians.



The preliminary telephone contact aimed to answer these above questions to determine if each centre would fit the needs of this project. Only thirty-four centres were found to fulfil the above conditions out of the initial fifty-one contacts.

Once satisfied with their suitability, the centres were contacted to request an appointment with their manager. Eighteen centres replied positively to this request. Therefore, the researcher personally met the manager and requested permission to invite psychotherapists to participate in this project and to be interviewed.

The Request for Participation Application (see below) was left with the managers. This application contained details about the purpose of the research, its aims, and objectives as well as an outline of expected outcomes and their utility. Fifteen centres then replied to confirm their intention for participation. An Informed Consent Form was sent to them. It provided them with specific details regarding the interview process and their right to withdraw from the research at any time prior to the writing of the dissertation.

**Request for Participation Application**

**Ms Mitra Babak**

**Specialist Consultant Psychotherapist**

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**Facebook page: [Facebook.com/mitrababakpage](https://www.facebook.com/mitrababakpage)**

**To,**

**Date:**

**Dear Sir/Madam,**

My name is Mitra Babak and I am a Specialist Consultant Psychotherapist with over 15 years of clinical experience in both the private and public sectors. I have been working with the NHS from 2001, where I created and provided Middle Eastern Family Counselling Services (MEFC) for Farsi, Arabic and Kurdish speaking clients. I also created and implemented a private weekly seminar/workshop called Farsi Psycho-

Educational Programme (FPEP). I appear weekly on an international satellite channel Manoto TV and Radio Omide Iran in Stockholm. I have appeared on numerous TV channels including the BBC where I have discussed psychological issues and created awareness about immigrant communities and mental healthcare need in the UK. For the past 27 years I have extensively studied and researched diverse aspects of Middle Eastern culture, social structures, languages, religions and politics.

I am currently involved in research that explores the effectiveness of available culture-based psychotherapy programmes for Iranian couples. The aim of my research is to find out how the diverse healthcare centres across the UK meet the mental health needs of this community, and to find out if any gaps in knowledge exist that need to be filled in order to provide better care.

This research is a part of my Doctorate in Psychotherapy by Professional Studies in Middlesex University and the Metanoia Institute thesis requirement. The title of my research is:” ***Developing an Intervention Psychotherapy Programme for the Needs of Iranian Immigrants in the UK***” but more importantly, it is a personal quest for me to develop a comprehensive and targeted psychotherapy programme that is aptly suited for Iranian couples and which can help them lead a more fulfilling life in the UK.

With my research I believe I would be able to add to the available literature on culture-based psychotherapy programmes for Iranian couples. More essentially, I aim to contribute toward the development of a practical and targeted psychotherapy plan that can be adapted by those psychotherapists and healthcare Centres that want to make a positive impact on the quality of life of the Immigrant Iranian community. My research

will also pave the way for further research towards the development of more targeted and specific programmes aimed at other Immigrant Communities in the UK.

With these aims in mind, I would like to request your Centre's participation in my research. More specifically, I would request to interview your psychotherapists who are involved in culture-based therapy for the Middle Eastern (and if possible, the Iranian) communities. The interviews would take between ½ hour and 45-minutes each and can be scheduled at the time and location of your convenience. The research when compiled and written will not reveal the name of the centre or the identities of the psychotherapists in any way and all information collected will be treated as confidential.

I look forward to your reply.

Thank you.

**Mitra Babak**

**Specialist Consultant Psychotherapist**

These fifteen centres were contacted to schedule interviews with some of their psychotherapists who were involved with immigrant Middle Eastern Communities. I asked to speak to therapists who had recently worked with Iranian clients, where possible. 20 interviews were scheduled. The list of the centres and letter of invitation to individual psychotherapists are provided below:

**List of Culture-based Psychotherapy Centres and Interviewed Psychotherapists**

1. Nafsyat Centre - <http://www.nafsiyat.org.uk/>
2. Institute of Family Therapy - <http://www.ift.org.uk/>
3. Refugee Therapy Centre - <http://www.refugeetherapy.org.uk/what-we-do/specialist-psychotherapy-counselling/couple-therapy.aspx>
4. Spectrum therapy - <http://www.spectrumtherapy.co.uk/>
5. Mental Health and well-being centre- [www.mhws.org.uk/](http://www.mhws.org.uk/)
6. EACH (Ethnic Alcohol Counselling in Hounslow) [www.eachcounselling.org.uk/](http://www.eachcounselling.org.uk/)
7. Birmingham Counselling and Psychotherapy Centre - <http://www.counselling-direct.co.uk/>
8. CCPE - <http://www.ccpe.org.uk/clinical.html>
9. OAKDALE - <http://www.oakdalegroup.co.uk/>
10. The London Centre for Psychotherapy - <http://www.lcppsychotherapy.org.uk/home.aspx>
11. Asian Family Counselling- [www.asianfamilycounselling.org/](http://www.asianfamilycounselling.org/)

The interview sample was drawn from names provided by the centres. Thus the sample was not randomly selected. A non-random sample may suffer the disadvantage that selected respondents may have certain attributes in common, such as their education level or their socioeconomic status, which are not present in the same proportion as in the main population (Robson 2011). Such a sample may be biased and thus, may not offer

accurate information. In this case, respondents were selected by the centres' managers (Saunders, Saunders, Lewis & Thornhill 2011), which can be seen as a problem in terms of the aforementioned possible bias.

These disadvantages imply that there is a probability that the information obtained from these sources may be biased, restricted or otherwise incomplete (Berg 2004). This suggests that psychotherapists may either have been instructed by the centres not to be candid; they may have felt obliged, in other ways, not to share their experiences with complete honesty.

To overcome these disadvantages, the interviews were conducted rigorously and the respondents were cross-questioned and asked to give complete and detailed opinions, as far as possible.

#### **6.3.1.2 Method of Data Collection**

Initially, a mixed method approach, as mentioned above, including the use of both quantitative and qualitative methods, was considered. However, that approach was discarded in favour of using a purely qualitative approach. This was because the perceptions of psychotherapists needed to be gauged in detail and a quantitative approach would not be useful in this regard.

The method of data collection involved two different approaches, which suited the two different parts of the research. The first part of the research aimed to obtain information related to the prevalent culture-based psychotherapy programmes for Iranian

couples in the UK, and endeavoured to obtain information on best practice used by psychotherapists across the UK when dealing with clients from Iran.

20 psychotherapists with experience working with couples from the Iranian immigrant community in the UK were elected from the aforementioned 15 psychotherapy centres across the UK. They were provided with an interview schedule based on a time and location that was convenient to them. The interview respondents were informed beforehand about the subject and focus of the interviews via the Informed Consent Form that they had signed and returned individually. Individual Informed Consent from each participant was essential, as per ethical considerations requirements.

The 15 interviews were scheduled at the centre premises and were conducted at either the office of each centre's manager, or at each psychotherapist's office. Each interview lasted between 45 minutes and an hour and 15 minutes. An open-ended, loosely-structured questionnaire was used to guide interviews. The questionnaire is presented below.

**Interview Research Questionnaire**

**Doctorate in Psychotherapy by Professional Studies**

**Middlesex University and the Metanoia Institute**

**“Developing an Intervention Psychotherapy Programme for the Needs of**

**Iranian Immigrants in UK”**

**By Mitra Babak**

**Questionnaire**

Name:

Designation:

Address:

Q1: What is the approximate number of clients that you get from the Iranian Community?

Prompt- can you give the number as well?

Q2: Can you tell me about the kinds of issues that immigrant Iranian couples present with in therapy with you? (Prompt if appropriate: do these include sexual issues? Their relationship with their in-laws?)

Q3: Can you think of some reasons why couples from the Iranian Community may be facing the above issues in the UK? (Some prompts: is adjusting to the work environment and culture an issue? If so, then how? Any issues related to general cultural changes they have to face?).



Q4: Why do you think that Iranian couples may have chosen your services? (Prompt – would you say that it is difficult for them to go to a Western based therapist? If so, then why?)

Q5: What do you think, is the role of ethnicity of clients in determining their expectations from psychotherapy?

Q6: What do you think is the impact of ethnicity on clients' perception of psychotherapy (that psychotherapy is effective that it will help them or not)?

Q7: What do you think is the role of ethnicity of clients in their following-up with all sessions and being regular in coming to sessions?

Q8: What are your expectations from clients that have therapy with you? What are your expectations from the Iranian clients who start therapy with you?

Q9. Can you please share with me the approach that you take for working with people from the Iranian clients?

Prompts 1: For example, can you elaborate on how you start your first session with clients from the Iranian community? Please give us a typical example.

After the answer of the above prompt has been received - Prompt 2: Do you give some activity for the clients between sessions?

After the answer of the above prompt has been received - Prompt 3: Do you decide beforehand what needs to be discussed in the next session? Or the client can just take up anything to discuss?

After the answer of the above prompt has been received - Prompt 4: What are the signs in behaviour/attitude of clients that make you start thinking that therapy is making a positive impact? When do you decide that the client does not need any more sessions?

After the answer of the above prompt has been received - Prompt 5: Is this (your approach to Iranian clients as you discussed above) different from what you do with Western clients?

Q10: You mentioned that clients from the Iranian community have false expectations from the therapist (like, the therapist is a magician and will give quick-fix solution) – how do you deal with this? (THIS QUESTION IS TO BE ASKED ONLY IF THE THERAPIST HAS SAID SO (FALSE EXPECTATIONS))

Q11: You mention that Iranian clients may be reluctant to discuss problems, especially sexual ones, for fear of being judged or out of cultural inhibitions about seeking out therapy for personal issues. What strategy do you take in order to draw out such clients? (THIS QUESTION IS TO BE ASKED ONLY IF THE THERAPIST HAS SAID SO (RELUCTANCE TO DISCUSS PROBLEMS))

Q12: You mention that clients from the Iranian community may have a different sense of honour, shame, perceptions and values. How do you deal with such notions in your therapy? For example, a spouse may be worried about her husband's drinking at office parties as it's against her religion. But, the husband may perceive that it is part of Western etiquette. In such cases, how do you proceed? (THIS QUESTION IS TO BE ASKED ONLY IF THE THERAPIST HAS SAID SO (DIFFERENCE IN VALUES, BELIEFS ETC.))

Q13: Do you think that there is a need for more training of therapists for meeting the specific needs of clients from culturally-diverse backgrounds?

Q14: Have you ever received any culture-based training? What is your view on the current available culture-based training? Prompt: As a matter of record, did you get any cultural training as a part of your graduation, PG or specialisation? (If the respondent says YES, then another prompt: Can you briefly describe the contents of that training please?)

Q15: Some people believe that additional training is needed for meeting the specific needs of clients from cultural diverse backgrounds. However, there are others who argue against this. What is your view?

Thank you for your time.

The face-to-face interview method is the most advantageous when compared to other forms of data collection. Interviews enable the researcher to obtain comprehensive information from respondents (Saunders et al. 2011). Interviews can lead to complete disclosure from the respondents, provided the interviewer is well-trained in conducting interviews (Gibbs 2012).

Interviews also provide the researcher with a chance to explore side issues and to moderate the conversation to yield additional information from the respondents (Shaughnessy, Zechmeister, & Zechmeister 2012). In addition, the face-to-face nature of data collection ensures that many contextual cues, such as body language, facial

expression and tone of voice can be used by the interviewer to enrich their understanding of the verbal information (Gibbs 2012).

### **6.3.1.3 Research Instruments: Interview Questionnaire**

The research used two basic research instruments that were relevant to the two parts of the data collection process. The first was a semi-structured questionnaire with open-ended questions, used to guide interviews. This research questionnaire contains questions related to the psychotherapists' opinions about the specific issues encountered in the immigrant Iranian community. It also explored the approach and methodology employed by the psychotherapists in dealing with couples from this community.

Therefore, the aim of this questionnaire was to obtain a large amount of in-depth and detailed information regarding available psychotherapeutic approaches adopted by professionals with their Iranian clients. It also focused on obtaining insight in terms of the prevalent problems encountered with these clients and the reasons the therapists might identify for these problems.

The questionnaire for these interviews was rooted in insights gained from the literature review that had already been conducted, as well as from my own clinical work with clients from the Iranian community. Further, the questions were tuned into the research aims and objectives, as set out in Chapter 1.

The researcher also sought the expert opinion of her research advisors, such as Dr. Nadia Aghtaie, who is a director of graduate research in the Security, Conflict and Justice Programme, or Professor Simon du Plock, Programme Leader/Link Tutor. Professor du

Plock has extensive experience with the development of research methodologies and also with research supervision. Their help and feedback on the interview questions made it possible to discard several leading questions. It was thus probable to make the questions more appropriate so that they could best assist in collecting the necessary information, to better answer research questions.

The interview questions were also formulated in light of the interviews that were already carried out, which will be presented in Chapter 7. A pilot study involving only one participant was conducted, which further enabled fine-tuning of the questionnaire. The questionnaire was expected to be substantially valid. The questions used in the questionnaire were based on the main research questions, which are recapitulated below:

1. What culture-based couple therapy programmes available for the Iranian community in the UK?
2. What are the reasons for disengagement or partial positive outcomes of couple's therapy for Iranians in the UK as indicated by the available literature?
3. What are the problems and challenges that couples therapists trained in Western approaches to therapy face when dealing with Iranians?
4. How can the couples therapists trained in Western therapeutic approaches improve the treatment outcomes and thus reduce the disengagement rate of their UK Iranian clients?

The first research question is directly focused on obtaining information on the culture-based psychotherapy programmes for the UK Iranian community. It incorporates aspects of the programmes used for Iranian clients, such as the structure of the sessions, the approach used, and the way in which therapy usually ends.

Questions 1, 9, 10 and 11 were related to the approximate prevalence of mental healthcare requirements among Iranian clients. They also involved the psychotherapists' approach to their work, the therapeutic 'tools' they used, and their methods of assessing the success of the therapy (Table 4):

<b>RQ1: What is the culture-based couple therapy programmes available for the Iranian community in the UK?</b>
Q1: What is the approximate number of clients that you tend to get from the Iranian Community?
Q9: Can you please share with me the approach that you take when working with people from the Iranian community?
Q10: Please elaborate on how you structure your sessions, or whether you assign any additional activities (out of session activities) as complementary to the sessions?
Q11: How do you bring about the therapy's end? What outcomes are you looking for to enable you to decide that the clients no longer need continued sessions of psychotherapy with you?

**Table 4: First research question (RQ1) and related questions**

The second research question was, 'What are the reasons for disengagement or only partial positive outcomes of couples therapy when it comes to UK?'

This question aimed to explore specific problems faced by the Iranian community in the UK, which may impact their mental health. It also aims to explore the impact of their perceptions of mental healthcare and of psychotherapy. Questions 2, 3 and 4 (Table 5), ask specifically about such issues, as well as the impact of the conflict between Eastern and Western cultures that Iranians may face in the UK, and socio-cultural factors that may make Iranians averse to seeking mental healthcare.

<b>RQ2: What are the reasons for disengagement or only partial positive outcomes of couples therapy for Iranians in the UK?</b>
Q2: What are some of the issues or specific problems that you find are predominant among Iranian couples? Can you please elaborate on these?
Q3: What do you think are some of the reasons for these problems that couples from the Iranian Community may face in the UK?
Q4: Can you think of any reasons, or any specific characteristics of Iranian people, that may make it difficult for them to access Western based therapists?

**Table 5: Research question and related questions**

The above questions aim to understand the culture-based peculiarities of issues that might be experienced by immigrant Iranian couples, rendering Western based psychotherapeutic approaches ineffective for them, or issues that may prevent Iranian couples from approaching therapy in the first place.

The third research question was, 'What are the problems and challenges that couples therapists trained in Western psychotherapy face when dealing with people from Iran?'

This research question guided the development of questions about the expectations of psychotherapists regarding their Iranian clients, which may presumably be influenced by their Western education. Questions 5, 6, 7 and 8 (see Table 6) elaborate on the specific problems psychotherapists may encounter when dealing with clients from the Iranian community.

<b>RQ3: What are the problems and challenges that couples therapists trained in the Western approaches to therapy face while dealing with people from Iran?</b>
Q5: What do you think is the perception of Iranian clients in cooperating and getting involved in the therapy process? Do you think that client cooperation and involvement is essential for therapy to be successful?
Q6: What do you think is the perception of Iranian clients about following-up with all sessions and about regular attendance to therapy sessions?
Q7: What would you say are the expectations of therapy that Iranian clients have, when they first came to see you?
Q8: What are your expectations from clients that have therapy with you? What are your expectations from Iranian clients who start therapy with you?

**Table 6: Research question 3 and related questions**

The final research question was, 'How can the couples therapists trained in Western therapeutic approaches improve treatment outcomes and reduce the disengagement rate of their UK Iranian clients?' (See Table 7) To answer this, respondents were asked to rate their success with Iranian couples (Q12: What would you say is your rate of success with Iranian clients?)

They were also asked to express their opinion about the need for more culturally targeted training for psychotherapists dealing with culturally-diverse clients (Q13: Do you think that there is a need for more therapeutic training with a goal to better meet the specific needs of clients from culturally-diverse backgrounds?).



They were asked if they believed there was scope for improving the available content of any culture-based training they may already have had (Q14: Do you think that the current culture-based training available to therapists can be improved?)

<b>RQ4: How can the couples therapists trained in the Western therapeutic tradition improve the treatment outcomes and reduce the disengagement rate of their UK Iranian clients?</b>
Q12: What would you say is the rate of success with Iranian clients?
Q13: Do you think that there is a need for more training of therapists so that they can better meet the specific needs of clients from culturally-diverse backgrounds?
Q14: Do you think that the current culture-based training available to therapists can be improved?

**Table 7: Research question 4 and related questions**

The final question of the questionnaire was inspired by researcher's own future aspirations in terms of providing targeted and focused training to psychotherapists for dealing with Iranian clients (Q15: Would you like to contribute towards the development of specific, comprehensive and country-targeted culture-based therapy programmes? If yes, then please indicate your reasons').

#### **6.3.1.4 Method of Data Analysis**

Data was analysed in several steps. Initially, interview findings were transcribed and stored. Next, SPSS software was used to analyse responses and generate thematic content analysis. These themes were further analysed using the theoretical framework identified in the literature review. The analysis was then presented in a visually appealing and easy to read manner, assisted by graphs and diagrams.

The next stage of the research involved using the findings from the interviews to update the basic PEP module. This was done in a subjective manner, using the insights that were brought to light by the interview findings. This is presented in the form of a comparison of the basic PEP module in the updated PEP module, which incorporates the new insights.

### ***6.3.2 Part Two: Focus-group***

#### **6.3.2.1 Research Sample**

The second part of the research focused on gaining further insight through use of a focus-group. This focus-group comprised a number of psychotherapists who have worked with clients from diverse cultures, including those from the UK Iranian community.

Using a focus-group to generate information is considered a suitable means of obtaining new insights and nuances, as well as of facilitating an in-depth and thought-provoking exploration of a particular subject (Creswell 2007). It was hypothesised that using the focus-group would complement the findings already obtained from the psychotherapists' interviews.

The updated PEP (amendments were made based upon the interview data) was presented to a group of professional therapists and their comments and suggestions were solicited. Five psychotherapists participated in this part of the research. They were selected from amongst the researcher's colleagues. At the time of embarking on the research programme, colleagues and acquaintances were asked whether they would be

interested in participating in the research. Positive replies were initially received from 15 candidates. It was possible to involve only five people in the final discussion.

The focus-group sample consisted of experienced psychotherapists who have worked with the Middle Eastern community and have specific experience in working with immigrant Iranian couples in the UK. All five participants have worked in the field for at least 15 years. The complete list of participants, without disclosure of their names and demographic details, were presented earlier in this dissertation.

This sample had two main disadvantages. First, it contained people known personally to the researcher for a long time, and is therefore possible that the group may have shared some of the researcher's own perceptions. In addition, they might have not felt comfortable to disagree with the researcher.

Moreover, there is a possibility that they may not have felt able to say what they really thought due to some perceived power relationship in the group. As the researcher is a public figure in the Iranian community, this might have placed pressure on the focus-group to confirm the researcher's point of view.

A second issue related to the fact that all these people lived in London meant that they may have encountered Iranian couples only from a certain socio-demographic group that tends to live in London rather than in other areas of the UK.

The first disadvantage was overcome, as far as possible, by assuring respondents that they had the freedom to voice their diverse professional opinions openly. The selected group of people did not know one another and had dissimilar training, professional backgrounds and career progressions. It can be hypothesised that their

different backgrounds ensured they had experience with diverse clients and hence that they could contribute individually and completely to the current research. Moreover, despite the public stature of the researcher, she has always been open, warm and welcoming, as well as nurturing and on equal terms in her relationships with each of the participants.

The five respondents were initially asked in an informal manner, if they were interested in participating. On obtaining their informal consent, they were sent the formal Informed Consent Form. On receipt of their signed informed consent, two focus-group sessions were scheduled.

Other ethical issues that arose were those of confidentiality and privacy. These were addressed by ensuring that the data was locked in a safe place, to which only authorised persons had access. Anonymity of participants was also ensured. This was done by using letters instead of real names.

#### **6.3.2.2 Method of Data Collection**

The second part of the research comprised focus-group discussions. Eight psychotherapists were selected for the focus group discussion, although only five ultimately participated. The proceedings of the two sessions of the focus-group were transcribed and videotaped with the consent of the participants. The two focus-group sessions were scheduled with a 15-day gap between them.

The aim of the focus-group discussions was to develop a deeper understanding of the perceptions of psychotherapists regarding the updated PEP module.

Focus-group discussions are considered extremely useful, particularly in exploratory research (Smith, Flowers & Larkin 2009), in which new ideas are generated or the aim is to brainstorm and to arrive at innovative solutions to problems (Robson 2011). In the current case, as all the participants were experts in the field of psychotherapy and had considerable experience with clients from Middle Eastern countries, including Iran, it was expected that a rich database of information could be generated from the focus-groups.

Focus-group discussions require a facilitator trained and adept at keeping the discussion on track, ensuring that all participants have a chance to voice their opinions (Gibbs 2012). Focus-groups might suffer the disadvantage of some dominant members of the group being highly vocal and overriding the opinions of others (Cohen, Manion & Morrison 2000). This might also lead to ‘group-think’ and ‘group-shift’ conditions, which may result in faulty decision-making by the group (Bénabou 2009).

Group-think occurs when the participants in a group-decision process endeavour to avoid conflict and thus all members adopting similar opinions (Schafer & Crichlow 2010). In the current case, it is possible that the opinions of the more powerful, intimidating and vocal members may have influenced other members to adopt a similar position.

Another problem in group discussions relates to the way people make decisions about risk. In the case of a group decision, there is the possibility that the perceived risk associated with the decision outcome is lower, as people tend to find safety in numbers (Gibbs 2012). In the current context, it is possible that the suggestions and

recommendations made by the focus-group members might not have been practical or might have been too innovative and enthusiastic, with little practical relevance.

The facilitator of the group may overcome these problems, at least partly. Shifts in group opinions were guarded against as far as possible, by being vigilant. Moreover, participants were reminded of the importance of providing their individual opinions, even when different to those of the majority of group members.

Several other disadvantages may manifest during focus-group discussions. For instance, it is possible that the discussions may continue indefinitely, without yielding concrete results (Bénabou 2009). To avoid this danger, a concrete timeline for the sessions was used, which ensured that they were steered forward with the required focus on the end-objective. Additionally, it was crucial that they would be completed within the time frame set for this purpose. The first session of the focus-group discussion was confined to a two-hour period, with a short break in between. The second session had duration of three hours, with the provision of a two-hour break.

Another disadvantage could be that the group members might not want to express their true opinions during the discussion related to their professional practice (Bryman 2012). However, it was possible to overcome this potential problem by reassuring them that they were not being judged, and instead that their contributions would be extremely useful. They were also assured that this information would be useful in enriching the literature focused on the Iranian community's mental healthcare needs.

In spite of these disadvantages, focus groups are considered useful for exploring new ideas and generating innovative insights (Berg 2004). Focus-group discussions are

used extensively by marketing organisations to understand the perceptions of target customer groups about new products or ideas (Bernard 2012).

In the current case, an analogy may be drawn as the aim of the research was to develop a culture-based psychotherapy programme for a specific population: immigrant Iranian couples. The psychotherapists involved in the focus-group were first-hand sources of information regarding the problems related to this community. These psychotherapists were seen as being in a position to offer insight about their experiences with the couples from the immigrant Iranian community, and to suggest modifications to the updated programme, so that it may be made more relevant for Iranian clients.

#### **6.3.2.3 Research Instruments: Focus-Group Questionnaire**

The focus-group discussions were facilitated by the use of another questionnaire, which contained a list of guiding questions. These questions were aimed at exploring the opinions of participants regarding specific problems faced by immigrant Iranian couples, and exploring participants' approaches in dealing with them.

Therefore, the first session of the focus-group discussion was undertaken in a structured manner, and a question as posed to lead to a group discussion. Each question or theme was discussed for several minutes, and the insights gathered were noted on a white board. This questionnaire is attached below.

### **Focus-group Leading Questions**

Q1: What would you say is the approximate number of clients that you get from the Iranian Community?

Q2: Do you find that there are particular issues or problems that are predominant among Iranian people, especially among Iranian couples? Can you please elaborate on these?

Q3: What do you think are some of the reasons for these problems that couples from the Iranian Community tend to face in the UK?

Q4: Do you think that there are specific characteristics (socio-cultural or having to do with upbringing related) about Iranian people that makes it difficult for them to access Western therapists?

Q5: Do you think that clients need to give their cooperation and be involved in the therapy process, for therapy to be successful?

Q6: Do you think that it is the responsibility of the clients to follow-up with all sessions and be regular in coming to sessions?

Q7: What would you say are the expectations of Iranian clients from therapy when they come to you?

Q8: What expectations do you have from the Iranian clients who start therapy with you?

Q9. Can you please share with me the approach that you take for working with people from the Iranian community?



Q10: Please elaborate on how you structure your sessions, and could you mention any additional activities (out of session activities) that you assign as complementary to the sessions?

Q11: How do you assess the success of your session? How do you assess the success per client?

Q12: What would you say is the rate of success with Iranian clients?

Q13: Do you think that there is a need for more training of therapists in terms of meeting the specific needs of clients from culturally-diverse backgrounds?

Q14: Do you think that the current culture-based training available to therapists can be improved?

Q15: Would you like to contribute towards the development of specific, comprehensive and country-targeted culture-based therapy programmes?

**Thank you for your time.**

*Interview schedule used in the pilot study*

**Part A: Analysis of Interview Responses**

**This interview respondent is from the Ethnic Alcohol Counselling in Brent, Harrow and Ealing (EACH). The respondent's name is Mr. G and he is a psychotherapist at this centre. The interview commenced with thanking Mr. G for his time.**

**Q1: What is the approximate number of clients that you get from the Iranian Community? Prompt—can you give the number as well?**

15% of clients coming to the Centre were of Iranian origin. When translated in terms of real numbers, this percentage is quite large. This centre has only one Farsi speaking counsellor but this counsellor works very efficiently.

**Q2: Can you tell me about the kinds of issues that immigrant Iranian couples present with in therapy with you? (Prompt if appropriate: do these include sexual issues? Their relationship with in-laws?)**

The conception of privacy is rather different in the Iranian community as marriage does not imply that issues need to be resolved just within the couple. So, even with the most intimate issues, the extended family's opinion matters and collective decision-making is often practiced. I have noted that many issues directly stem from the interference of one person in the family, the mother-in-law or the wife.

On the issue of the mother-in-law, it is a matter of routine for Iranian couples to face interference from their in-law, especially from the husband's mother of the husband. This meant that in addition to the regular compatibility issues between husband and wife,

there tend to be additional, completely avoidable issues that are created due to the regular presence and interference of mother in-laws.

Most often, there tends to be a tussle between self-identity and the individual's expected or perceived role within the wider family. There is a regular sharing of space and emotions with the extended family, which often creates conflict when it comes to the self-interest of individual spouses. There is a concept of family enmeshment, not over-emphasising the self or personal needs in the Iranian community.

Also, Iranian people have to deal with the ideas of collective and individual benefit. Culturally, Iranians belong to a collective society so they are used to placing others and their family ahead of their individual needs. This leads sometimes to feelings of suffocation or guilt alternatively. Suffocation has to do with placing other people's needs before one's own, and guilt has to do with the times when personal needs may take precedence over family's needs.

The most common issue dealt with by Iranian couples coming to talk about sexual issues is related to female sexuality. Men often complain that their partners are not sexual enough. This lack of interest in sex can lead to estrangement between couples and often pushes the male partner toward gratification outside the marriage. Infidelity in turn can lead to guilt and stress within the marriage. So, sexual incompatibility can be an issue due to inhibited libidos particularly in female spouses. This sort of inhibited behaviour has to do with the psyche of the women from the Iranian community, who have been culturally encouraged to be modest, shy and uninterested in sex.

This is not the only sexual issue, which tends to occur with clients from the Iranian community. I have witnessed that often, women would like to be more assertive in terms of their sexual needs, which they feel are repressed by their husbands. This is because, in Iranian culture, sex is considered as mostly the prerogative of the male, where the husband needs to satisfy his needs and the woman acts in a supporting role. With this mind-set, the husband does not need to bother about satisfying the wife, and rather, uses her for self-gratification.

When Iranian couples live in a Western society that is more open about sexuality and especially in terms of the expression of female sexuality, there can be a change in the expectations of Iranian women as to what they expect from their husbands. But, these expectations may remain unmet, leading to alienation and problems in their marital lives.

So, it can be said as a conclusion that the difference in the way men and women view sex is one of the issues that lead to marital discord among Iranian immigrant couples.

**Q3: Can you think of some reasons why couples from the Iranian Community may face the above issues in the UK? (Some prompts: is adjusting to the work environment and culture an issue? If so, then how? Any issues related to general cultural changes they have to face?).**

The Iranian couples living in the West do face a lot of challenges due to the difference in their values and belief systems compared to those that prevail in the West. One issue that they regularly face is that there is a language barrier and they are thus not able to be expressive. For most of the first and even second-generation Iranians, English

is a second language and even though they can understand English really well, they find speaking it rather difficult. This may lead to communication issues--both at work and in general.

Another challenge is related to the openness about sex and sexuality that is prevalent in Western society. In the UK almost all the public media is sexualised—in TV, movies, billboards and even conversations between friends and colleagues. This environment pushes the boundaries too much to their liking. Not only is Iranian culture modest and repressive about the expression of sexuality; Islamic religion also places considerable restrictions in such conduct. In the West, Iranian people encounter sexual connotations almost everywhere, and they do not want to be part of this. But, since they have to participate in the community and in work life, this issue can create feelings of stress, guilt and maybe even anger.

I have noted another challenge that is related to the issues of shame and honour. Iranian culture has a deeply ingrained sense of honour and any deviation from norms and ethics leads to an exalted sense of shame.

I have come to understand that the lack of ability to effectively communicate leads to low self-esteem and lack of confidence in both professional and social settings for Iranian clients. I have also encountered clients who have felt intimidated by the overly sexual nature of communications, conversations, and even public messages that are available in the UK. Iranian clients appear to fear for their sense of integrity, as they are continuously tested to accept and even assimilate all that they had been brought up to consider as taboo. I think the issue—related to honour and to the sense of shame, is one

of the most common issues that I have encountered. So, while it may be okay for a native Londoner to allow his or her daughter to date, this may lead to a sense of dishonour if an Iranian immigrant's daughter does the same, since in their culture it is taboo for women to meet men before marriage. Or, while it is okay in the UK for women to shake hands and meet men casually, it may be perceived as a cause of shame if an Iranian woman does this.

**Q4: Why do you think that Iranian couples may have chosen your services? (Prompt – would you say that it is difficult for them to go to a Western therapist? If so, then why?)**

I think the reasons that Iranian couples may have chosen the centre or me personally are many. First, since the centre is an Asian one, Iranian people tend to believe that the people here might be in a better position to relate to their problems and to empathise with them. This is because of the perception that Asian communities share a basic set of core values like collectivism and cooperation, respecting elders and sacrificing self for the greater good. These set of values are not evident in Western cultures, and so Iranian people may feel awkward with a Western centre or with a Western psychotherapist.

Secondly, at centres that have therapists speaking Middle Eastern languages or, specifically, Persian, Iranian couples believe that they would be better able to communicate. As English is their second language, it is difficult for them to express themselves fluently. In the case of a therapist who speaks their language, communication

is of course more fluid and more in-depth. This creates more of a sense of comfort for Iranian couples.

Thirdly, there are several stereotypes associated with Western people. It is possible that Iranian couples perceive Western psychotherapists as cold, distant, judgmental, professional, and impersonal. These perceived attributes may act as barriers for Iranians who need psychotherapy. Instead, psychotherapists who are perhaps of the same colour or ethnicity, who speak the same language, and who come from a similar background, may be expected to provide a more empathic and personal approach to psychotherapy.

Iranian people have reported to me several times that they either tried a Western psychotherapist but were intimidated, or they did not try at all as they feared being adversely judged. While it is wholly true that there is no basis for such assumptions about Western psychotherapists, these stereotypes need to be considered as they exist and more often than not, can guide people's actions towards others. The same stereotyping is evident in the context of Iranian couples that appear to be biased against Western psychotherapists.

EACH centre is community based; this means that it is not only located close to Asian communities; it also recruits staff from within the community. This way, the centre is very close to local people. Clients perceive it as understanding of their issues simply because it is a part of their own community. They may also assume that the psychotherapists at the centre are familiar with Iranian couples' lifestyle, challenges, inhibitions and attitudes toward the West and towards the Western way of life."

**Q5: What do you think is the role of the clients' ethnicity in determining their expectations from psychotherapy?**

Iranian clients perceive psychotherapy as something that should be able to provide them with final answers to their problems. As such, they expect the psychotherapist to be authoritative and to provide them with full solutions. So, Iranian clients look for expert guidance that can solve their problems.

In my view, the concept of self-empowerment or taking responsibility for one's own happiness is alien to Eastern people, including Iranian couples. Iranian couples expect, as I said, the psychotherapist to take a leading role and to provide them with ready-made solutions. The most common Iranian clients' expectation from their therapist is to "fix me" or fix "him/her" or "give a solution or a medicine to can take away my problem".

I cannot be critical about this tendency in Iranian clients; they have been culturally accustomed to thinking in this way. I feel that they have not had the choice of developing a sense of individualised accountability as it is an alien concept for them.

I have witnessed these sorts of expectations from Iranian couples in psychotherapy with me. As I have said, this expectation of coming to a psychotherapist to 'get fixed' makes sense in the context of Iranian culture. The concept of 'taking the initiative to mend yourself' is not encouraged; instead, one is expected to look towards elders or to consult with experts for guidance. There is often a village elder, for example, who is consulted to offer 'on the spot' solutions for problems.



Iranian people also expect, however, that the counsellor should have empathy and take an authentic interest in their problems. This expectation stems from the fact that Iranian culture encourages community living and collective decision-making for all problems. By extension, Iranian people expect that their therapist should be readily and authentically involved in their problems, and should at the same time give them accurate solutions. Iranian clients therefore do not expect that they will be required to actively participate in the process; instead they look for quick-fix solutions, like getting an antidote to their maladies, without getting involved in the production of that antidote.

Some other expectations include a wish to receive age-appropriate respect from the psychotherapist. In Eastern cultures, age is respected and people who are elder to you expect to be treated with deference. In fact, the older a person is, the wiser and more knowledgeable he is considered to be. On the other hand, in the West, age is not considered an achievement; rather, some people consider old people more of a burden rather than seeing them as having valuable contributions to make in society or in the family with their experience.

In some cases, Iranian clients are friendlier than in other cases, and they expect to have an informal and pleasant conversation with the therapist. It is usual among Eastern cultures that when one meets someone, he or she shares some family trivia and enquires about the health and wellbeing of the other's relatives. This seems to be the expectation of Iranian clients when they meet a therapist.

These findings from Dr G complement my own experience with clients from the Middle East and especially from Iran. As I have already mentioned in Chapter 2, my PEP

was developed using these insights about Iranian couples' expectations from therapy. These insights included knowing that Iranian couples liked to believe that the therapist is an authority figure who can firmly guide them to a solution; and that the therapist is at the same time empathetic and non-judgmental.

However, in most Western psychotherapy models, like person-centred therapy and cognitive-behavioural therapy, there is a focus on the client; the aim is to guide the client toward self-realisation and towards developing a sense of empowerment.

There is therefore an inherent clash - in the expectations of a Western psychotherapist and those of Iranian clients, which need to be reconciled if effective therapy is to be provided to this community.

**Q7: What do you think is the role of the client's ethnicity in their following-up with all sessions and being regular in coming to sessions?**

I have observed reluctance on the part of the Iranian clients for continued and long-term therapy. As a result, the dropout rate is high. Iranian couples expect speedy solutions from their therapists. Therefore, these clients may find little incentive to come to session after session and to go through the entire process of self-awareness and realisation. Many clients from the Iranian community therefore tend to give up on therapy after a couple of sessions, as they may perceive that a solution is not going to be handed down to them on a plate.

This attitude of Iranian clients is rather different from the attitudes of my general clientele. In the general population (comprising of mainly the Western communities), clients are expected to have patience and to place trust in the slow but definitive purpose

of psychotherapy. This is because, in most Western societies, the onus of being happy and taking care of one's physical and mental health lies with the individual. This background makes Western clients more able to get involved with the psychotherapy process at a more intimate level as they believe that the therapy's success falls on them as much as it does on the therapist.

This perception is non-existent among Iranian people who may have the mind-set that it's the therapist's job to 'cure' them. The reason behind such a mind-set could be because they have an external locus of control and believe that external reality (rather than themselves)—such as fate, luck or such as other people—may be in control of what happens to them.

In addition, at times, Iranian clients may continue therapy just because they want to appear amicable or they want to please the psychotherapist. This approach may not be effective as the clients still do not have an insight about how psychotherapy works and / or that they have to make a real effort and genuinely get involved in a self-introspection process.

**Q8: What are your expectations from clients that are in therapy with you? What are your expectations from Iranian clients who start therapy with you?**

My first expectation is that the client should turn up for sessions and should become engaged with the process. Iranian clients tend to not be regular in their sessions and often dropout altogether.

My next expectation is that clients should be open and forthcoming with the therapist. It is difficult though for Iranian couples to open up initially, as they are probably not used to discussing family matters outside of their family.

My other expectation is that clients should have patience, some self-direction and an open mind in order to understand the psychotherapy process and to have some readiness to make changes. It is important for the clients to have a degree of self-direction and to take responsibility for solving their issues, with the therapist's help; I have these expectations even though it is wrong to expect these responses from Iranian couples. This was because Iranian culture does not teach people to assert themselves and to take responsibility for their actions. Instead, they are taught to live in a collective and community environment where the problems and troubles of all are shared and solved by the combined efforts of family and friends. With such an upbringing, it is difficult for Iranian people to comprehend problem-solving tasks that require them to take individual responsibility and action with an aim to change themselves.

Since I do not expect all my clients to show cooperation and motivation for therapy, I need to adjust my expectations in terms of Iranians and many other Asian clients. I expect all my clients to be honest and direct with me, to give full information openly, and to have patience so that the full process of therapy and recovery can be undertaken. These expectations need to be cautiously applied in the context of Iranian clients.

**Q9. Can you please share with me the approach that you take when working with people from Iranian clients?** (Prompt 1: for example, can you elaborate on how you

start your first session with clients from the Iranian community? Please give us a typical example. After the answer of the above prompt has been –received: Prompt 2—do you suggest some activities or homework for clients between sessions? After the answer to the above prompt has been received—prompt 3: do you decide beforehand what needs to be discussed in the next session? Or can the client just take up anything to discuss? After the answer to the above prompt has been received—prompt 4: what are the signs in behaviour/attitude of clients that make you start thinking that therapy is making a positive impact? When do you decide that the client does not need any more sessions? After the answer to the above prompt has been –received—prompt5: is your approach to Iranian clients as you discussed above different from what you do with Western clients?

I do not use a standard approach with all clients. I can empathise more with clients from my community since I have had similar experiences in the UK. However, I do not let my own issues and experiences taint my therapy sessions or transfer what I have experienced to my clients.

At first, I used to give homework to my clients; but then I realised that non-English speakers but also some English-speaking clients would not do the homework at all, so, later, instead of setting tasks, I would ask clients what they intended to do during the week or between the sessions. If the clients set tasks for themselves, they could be expected to complete them.

Reading and writing related tasks rarely or never got done by my clients, even though I still like to give some tasks to my English-speaking clients especially when there is expected to be a long break between sessions. I have noticed that my Iranian clients do

not want to be ‘told’ and they do not like to set tasks. They want to be respected; so, for example, I avoid using first names for clients who are older than me. I try to maintain a balance between friendliness and objectivity.

**Q10: You mentioned that clients from the Iranian community have false expectations from the therapist (like the idea that the therapist is a magician and will give quick-fix solutions)—how do you deal with this? (THIS QUESTION IS TO BE ASKED ONLY IF THE THERAPIST HAS SAID SO (FALSE EXPECTATIONS)).**

**Q11: You mention that Iranian clients may be reluctant to discuss problems, especially sexual ones, for fear of being judged or because of cultural inhibitions having to do with seeking therapy for personal issues. What strategy do you take in order to draw out such clients? (THIS QUESTION IS TO BE ASKED ONLY IF THE THERAPIST HAS SAID SO (RELUCTANCE TO DISCUSS PROBLEMS))**

**Q12: You have mentioned that clients from the Iranian community might have a different sense of honour, shame, perceptions, and values. How do you deal with such notions in your therapy? For example, a spouse may be worried about her husband’s drinking at office parties as it’s against their religion. But, the husband may perceive that its part of the Western etiquette. In such cases, how do you proceed?**

**(THIS QUESTION IS TO BE ASKED ONLY IF THE THERAPIST HAS SAID SO  
(DIFFERENCE IN VALUES, BELIEFS ETC.)**

**Q13: Do you think that there is a need for more training of therapists for meeting the specific needs of clients from culturally-diverse backgrounds?**

It is important for psychotherapists to undergo further training so as to meet the needs of clients from culturally-diverse backgrounds. This can enable the therapists to understand the challenges their clients face and the impact culture has on their lives.

**Q14: Have you ever received any culture-based training? What is your view on the currently available culture-based training? Prompt: As a matter of record, did you get any cultural training as a part of your graduate or post-graduate training or during your specialisation training? (If the respondent said YES, then another prompt: Can you briefly describe the contents of that training please?)**

I have undergone a module of culture-based training but I do not remember when, where or in what context it was. I have not undertaken any additional or specialist training whatsoever, in any formal capacity. Even if the quality of training was high, training can at best teach you about different cultures, but it can't teach people the cultural determinism that deals with the belief that the culture in which an individual is brought up serves as the framework for their personality at behavioural and emotional level. Culture-based therapy has to come from the heart and not the head. Cultural sensitivity training needs to be encouraged though, if it can help therapists to increase

their knowledge about culture, but also to increase their willingness to use that knowledge to deal with clients in a sensitive and empathic manner.

**Q15: Some people believe that additional training is needed for meeting the specific needs of clients from cultural diverse backgrounds. However, others argue against this. What is your view?**

I agree that additional cultural training is needed, simply because there are so many immigrants. The UK is a truly multi-cultural place and it is important that a cultural understanding is encouraged, so that therapists are made more aware of the diverse beliefs and value systems of different clients.

**Thank you for your time.**

The second and final session of the focus-group was less structured. The first half of the session involved a presentation by the researcher on the updated PEP module. The second half of the session required participants to provide direct feedback and suggestions for the updated PEP module.

#### **6.2.3.4 Method of Data Analysis**

Next, the video-tapes of focus-group discussion were transcribed and the content from the first session was fed into NVIVO. Thematic content analysis was used to generate themes derived from the two focus-group discussions. These themes were then further analysed using the literature review and the theoretical framework.



The insights gained from this analysis were further incorporated into the updated PEP, which was now renamed, Advanced PEP, and presented during the second session of the focus-group. Further insights from the feedback of the five psychotherapists were used to improve and develop a final version of the PEP module.

## **CHAPTER 7: RESULTS AND DISCUSSION**

### ***7.1 Introduction***

The results and discussion chapter is dedicated to presenting the key findings of this research, as they emerged after collecting the data and analysing the findings. As this research aimed at finding a model psychotherapy programme for Iranian clients in the UK, data was collected from primary sources, from a number of UK-based Iranian and non-Iranian therapists. They shared their experiences on various issues related to culture model to bridge the cultural gap in psychotherapy.

Data was collected via interviews conducted with five different therapists, with a varying range of years of experience. 19 questions were posed to interviewees. Each respondent was free to respond as he or she desired.

In developing the interview questions, identification of a suitable theoretical construct, i.e. the most suitable psychotherapy approach for culturally-diverse clients, was necessitated. The questions had to be specific to Iranian clients, reflecting their challenges, their perspectives on therapy, and their reasons for disengagement when that occurred. Interview questions needed to generate a wide range of information related to the theoretical construct. Initially, fifteen participants committed to interviews; only five fulfilled their commitment.

The 19 questions were divided into five major themes to reflect the research questions and specific objectives outlined in the first chapter of the study. Analysis of the findings is presented, supported by relevant literature preceding each set of findings.

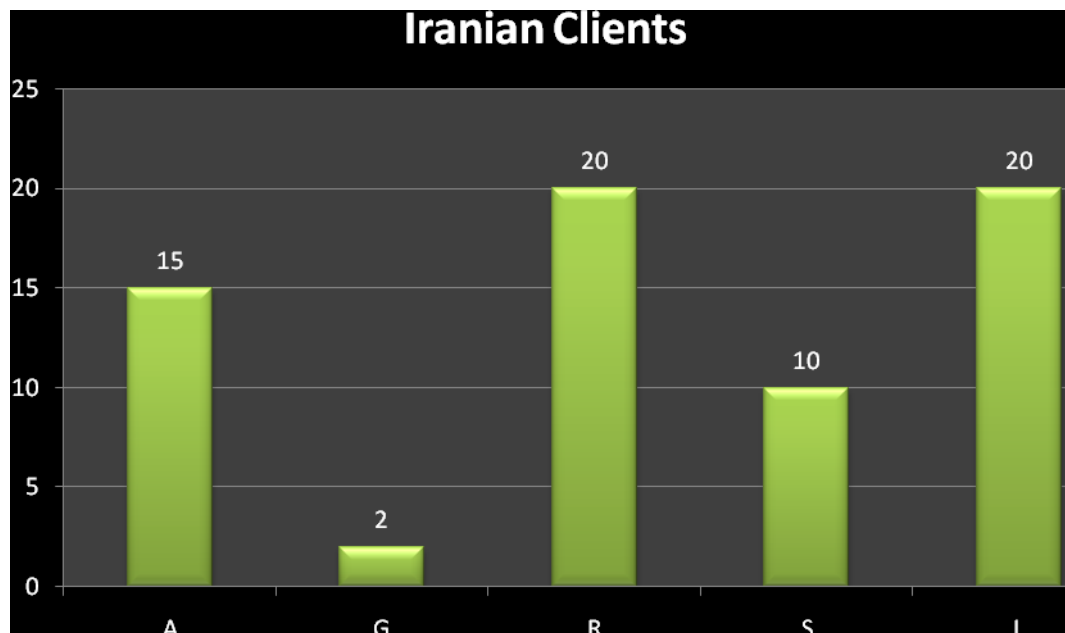
Thematic analysis was employed to analyse the pattern of participant responses. Thematic analysis is qualitative in nature, facilitating investigation of patterns and classifications connected with the data. It allows presentation of data in an inclusive mode with the involvement of diverse themes by consideration. This form of analysis is appropriate mostly for studies based on explanations because it eases the analysis of data in a methodical way (Ibrahim 2012). This method of data analysis was selected because it allowed a thorough investigation of participant responses. Five major themes emerged from the analysis. Sub-themes were subsequently distributed under the main themes.

## ***7.2 Factors that Influence Selection of Therapists***

Under this theme, questions were asked to detect the core factors considered by clients in selecting a particular therapist. Three major questions fell under this theme.

### ***7.2.1 Cultural Factors in the Selection of Therapists***

Therapists were asked about the percentage of Iranian clients they tended to see in their professional practice, in order better to understand factors influencing the selection of Iranian therapists by Iranian couples. The five therapists offered a variety of responses to these questions. Four respondents were British; one was Iranian. The results are presented below (see Figure 4):



**Figure 4: Comparison of the percentage of Iranian clients seen by Iranian and British therapists. A, R, S and L are British while G is Iranian**

20% of Iranian clients were received by ‘R’, a senior cognitive-behavioural therapist and by ‘L’, a couples’ therapist. ‘A’, a senior counsellor, received 15% clients whilst S, who practises CBT, received 10% clients. ‘G’, whose theoretical orientation is family therapy, received the least recorded clients.

‘G’ reported that in her private practice, she received up to 80% Iranian clients. The average number of Iranian clients seen by different therapists was 13.4%. Aligning these data with the relevant literature by Muntigl and Zabala (2008) may lead to conflicting conclusions. In their research, it was argued that cultural factors are predominant in influencing the selection of a therapist.

A reason for the reduced number of Iranian clients attending therapists in the UK is based on the fact that most of the therapists cannot provide cultural-based therapy to

Iranian clients. It appears that Iranian clients do not trust therapists who do not have an understanding of Iranian culture. As most of these therapists were born and trained in the UK, it may be expected that they would have more clients from the UK than from Iran.

### ***7.2.2 Reasons for Iranians Choosing Services by Iranians***

Therapists were interviewed so as better understand to understand the position of clients when choosing a therapist and to clarify whether and why they would choose an Iranian therapist. It was assumed that, provided the therapists' experience with clients, they could deduce from psychotherapeutic material the potential reasons behind choosing a particular therapist.

The researcher wanted to know why Iranian clients may select Iranian rather than Western therapists. 'A' explained that 'most Iranian clients expressed satisfaction at the fact that they could have someone who can easily have empathy for them when talking about their problems.' 'G' attributed the underlying reason to cultural similarities. However, 'G' raised an important point concerning the possibility that Iranian clients may also be uncomfortable with Iranian therapists. 'G' stated: 'Iranians may not choose Iranian therapists because of a fear that their issues will not be confidential as they are from the same cultural background.' She emphasises 'clients may feel embarrassed, especially if the issues they express conflict with what is culturally conventional or acceptable.' 'R' indicated that selection choice is based mainly on individual differences, such as educational background. Both 'S' and 'L' emphasised issues of language and cultural acceptability.

### ***7.2.3 The Reasons behind Difficulties Experienced by Iranians when Attending Western Therapists***

According to Markova and Foppa (2011), when a person prefers one person to another (thus, one therapist over another) in psychotherapy, this is entirely different from a person deciding not to use a whole service. Some core reasons significant in the ethics and approach of a client might include cases in which someone decides not to work with a particular therapist (Ferrara & Bell 2005). The interviewees in this research were required to share their experience with clients, exploring why their clients may have had difficulty using therapy services that were not part of Iranian culture. Answers were similar to those above. For instance, ‘A’ stressed that ‘most clients do not feel that Western therapists will understand them from a cultural point of view.’

Responding in a similar manner, ‘G’ added that most issues brought before therapists are related to culture, such as the inability to adjust to British culture and cultural family issues. Consequently, clients do not want to engage with people who cannot have a clear understanding of, and perhaps cannot completely accept, their culture.

‘R’ maintained that ‘it is all about personal differences and that an Iranian with a better understanding of psychotherapy would not have a problem with the background of the therapist.’ This implies that ‘R’ believes a therapist’s cultural background does not matter in psychotherapy. Similarly, ‘L’ stated that a major hindrance to psychotherapy was a lack of understanding of its core practice.

Thus, both ‘L’ and ‘R’ agreed that if clients were educated enough, they might be better able to understand psychotherapy as a profession. As a result, they would not have a problem with the therapists’ cultural background. This data constitutes inferences on the part of the therapists, not direct information from clients.

#### ***7.2.4 The Need for Culture-Based Therapy***

Sub-themes were informed by finding out about the needs of Iranians in the UK and by making use of culture-based therapy. Four major questions were posed to investigate this theme further:

### ***7.3 Common Issues Faced by Iranian Couples***

The second question was related to the most common issues experienced by Iranian couples, and thus presented to therapists in sessions. The issues that arose were widespread. ‘A’ mentioned a variety of issues, including addiction, relationship problems, gender difficulties, and family conflict. ‘G’ emphasised that ‘the most common issues I have heard have to do with relationship problems, the experience of being victims of torture, general coping issues, and family issues.’ ‘R’ conversed about issues of social class, relationship difficulties, infidelity and sexual problems. According to ‘S’, social adjustment and social anxiety were the most critical issues, whilst ‘L’ mentioned identity difficulties, work-related problems, and experiences of isolation from the original culture.

These responses align with the cultural problems commonly faced by immigrants, as discussed in the literature. Davis (2006) mentioned that most immigrants who travel from East to West have difficulties with identity, labour differences, and experiences of isolation in terms of culture and social class. They may also face other forms of discrimination, suggesting that the issues brought up by the clients are not specific to them, but similar for all immigrants. Apart from social issues, the Iranian couples also reported some difficulties in their interactions with people from their culture.

#### ***7.4 Reasons for Some of the Problems Faced by the Iranian Community in the UK***

Therapists were asked what may account for the problems faced by Iranians in the UK. Antaki, Barnes and Leudar (2004) noted that when therapists have a better understanding of the causes of problems faced by their clients, they are better able to address these problems.

‘A’ stated that ‘most of these problems are caused by an inability to adapt [to UK society] as quickly as expected.’ ‘G’ discussed difficulties immigrants may have accepting Western culture. ‘R’ expressed a similar opinion: ‘most relationship problems come up because most Iranian wives want to enjoy the kind of freedom available to Western women.’ ‘S’ felt some of the issues may be attributable to a refusal, on the part of Eastern people, to accept Western culture.

These responses, most of which attribute the problems faced by Iranians to cultural differences, suggest that an approach that promotes culture-based therapy may



encourage clients to express themselves more openly, and to feel therapists are trustworthy and understand their troubles (Barnes & Moss 2007).

### ***7.5 Openness of Iranian Couples with Sexual Difficulties***

To ascertain the need for culture-based therapy, it was crucial to examine whether major cultural differences exist in how Iranian and Western clients perceive sex. Whalen and Zimmerman (2007) argue that, when dealing with the issue of sex, culture is important in determining how different people approach the subject. Wetherell (2008) stressed that sexual issues are some of the most important issues faced by couples, across cultures.

Although Iranian couples may have sexual issues, they may find it more difficult to disclose these to people who do not share their cultural understanding. One of the interview questions therefore asked about whether therapists had noticed that clients found it particularly difficult to talk about sexual issues.

All five respondents confirm this. For instance ‘**R**’, a senior cognitive-behavioural therapist, said, 'female Iranian clients are able to express themselves more easily about sexual issues when they are in a one-on-one session with me than when their husbands are present.' They may also be afraid to discuss sex with another man in the presence of their husbands. ‘**S**’ who stated that unless she introduced the subject in a manner the couples found culturally acceptable, they could barely talk about sexual issues: ‘Most clients cannot feel comfortable with therapists who cannot approach sexual issues from a cultural perspective.’

‘G’ noted that ‘another challenge is related to the openness about sex and sexuality that is prevalent in the Western society. In the UK, almost all public media is sexualised; in the TV, in movies, in billboards, and even in conversations between friends and colleagues. This environment pushes the boundaries for Iranian immigrants. Iranian culture is not only modest and repressive in terms of expressing oneself sexually and discussing sexual issues; Islamic religion severely restricts such conduct. In the West, Iranians encounter sexual connotations everywhere, and do not feel comfortable being a part of this environment. Since they have to participate in life while residing in the UK, however, this often creates stress, guilt and even anger.’

Issues of sex and sexuality are certainly one of the most prevalent in the group of clients on which the therapeutic programme and dissertation is based. It is a major root of issues between Iranian couples and, because it is taboo, they need professional help in breaking these taboos in order to address the underlying issues. As evident from discussions of other key aspects informing conflict in Iranian immigrant marriages, this is by no means the only—or always the central—issue. It is nevertheless very important to the work here, given its emotive nature and its importance in marriage. Sexual issues may be difficult to discuss regardless of culture, and additional cultural restrictions on the topic exacerbate this difficulty.

### ***7.6 Success Rates with Iranian Clients***

All therapists interviewed reported attempting to approach their clients from a culture-based perspective. Even ‘R’ and ‘G’, who did not feel the need to be culturally

congruent, felt that disregarding basic cultural factors could make clients uncomfortable. 'R' stated: 'I always ask clients if I can shake their hands before doing so because I never know how they will take that.'

It was vital to know whether therapists thought culture-based therapy would have a positive impact on clients. Question 15 asked about therapists' success rate with Iranian clients. Psychotherapeutic success has proved difficult to quantify, and is usually operationalised in qualitative terms (Zimmerman & Whalen, 2008). Nevertheless, some conclusions about success rates with Iranian clients may be drawn, based on the interviews in this study.

Interview analysis revealed that therapists' success rate with Iranian clients was relatively low, despite most therapists ('A', 'S' and 'R') believe that therapeutic success depends on a number of goals, including the specific problems of the client. 'G' said, 'I generally judge the success rate with Western clients as higher than that with Iranian clients,' and 'A': 'psychotherapy originated from the West and so you would expect Western clients to achieve higher outcomes with it.' A tentative conclusion may be drawn that the success rate with Iranian clients in this sample is relatively lower than with the Western clients.

### ***7.7 Attitude of Clients towards Psychotherapy***

This section considers cultural issues influencing the attitude of clients towards psychotherapy. The attitudes of Western and Iranian clients are compared. Western clients are usually assumed to be more knowledgeable about the process of

psychotherapy. Without this knowledge, Iranian clients may have specific expectations from therapists. Questions 7, 8, 9, and 10 were designed to explore this theme.

### ***7.8 Perception of Iranian Clients on Psychotherapy Process***

British and Iranian value systems differ. This is largely due to different cultural environments. Thus, there understanding of psychotherapy necessarily differs and so do their expectations of therapy. Therapists were interviewed about their clients' perceptions of psychotherapy.

'R', 'S' and 'L' said that their Iranian clients perceive psychotherapy as a practice by which the therapist 'fixes' the client. Thus clients usually present their problems in the hope that therapists will provide detailed guidelines towards a solution.

'A', 'R' and 'L' said clients attend sessions seeking medical intervention for their problems. 'G' said, 'I deduce that some of my Iranian clients do not have much understanding of the whole process of psychotherapy', and 'R': 'the clients' perceptions about psychotherapy are dependent on their educational background.' The therapists believed their Western clients possessed a better understanding of psychotherapy than those from Iran.

Zimmerman and Whalen (2008) note that psychotherapy originated in the West. It is thus a part of daily life and culture for Western individuals, who therefore tend to perceive it more clearly (Ibid 2008). Wetherell (2008) supports the need for culture-based therapy, in which similarities between client and therapist are integral in facilitating understanding and accepting the particular needs of clients.

### ***7.9 Impact of Client's Ethnicity in Client Engagement and Expectations***

Questionnaire 8 compared the relationship between client ethnicity and engagement with or expectations from therapy. This was designed to investigate the degree to which clients involve themselves therapy sessions, as well as the kind of expectations they have, and how this may relate to their ethnicity.

'A' was emphatic that religion and education influence client expectations. For most clients, level of engagement was not dependent on level of education or religion, but rather to ethnic and cultural factors.

'G' and 'L' expressed similar opinions, indicating that most clients' expectations about therapy were centred on the need for some kind of cultural acceptance; because they are immigrants, they feel like strangers in a strange land. 'S', for instance, noted that 'most of my clients are new immigrants who have issues with how to settle in the new culture.'

'R' offered a different perspective: 'education is more predominant than culture and Iranians who have higher levels of education can engage in psychotherapy that uses a more "open" [not culture-based] approach.' He later emphasised the importance of level of education. 'S' indicated that the most important thing is the method used by the therapist to facilitate the client's engagement. For instance, in the first session, she sees couples together; later, she sees them individually, in order to engage with them in more depth.

Therefore, three major factors emerged: promoting engagement; influencing clients' expectations about therapy, including ethnicity and level of education; and the

therapist's approach. Those clients who have already lived in the UK for several years and those with a good level of educational, especially younger people, tend to be more open during communication with the psychotherapist.

### ***7.9.1 Rate of Following up of Sessions until Termination of Therapy***

According to almost all interviewees, Iranian clients tend to disengage from therapy relatively early. Some Western clients also disengage, but the rate is disproportionately in favour of Iranians clients.

Clients' attitude towards psychotherapy is influenced by the 'fallout' rate (Sudnow, 2007). A lack of understanding about the psychotherapeutic process makes it disengage before the completion of treatment more likely.

It is noteworthy that the rate of disengagement among Iranian clients is higher compared to Western clients in this sample. This confirms evidence from the literature. Most interviewees indicated that their Iranian clients had less of an understanding of what psychotherapy entails as it originated in the West and was therefore absent from their cultural upbringing.

### ***7.9.2 Therapists' Expectations of Clients***

Following investigation of clients' attitude towards psychotherapy as perceived by therapists, it was crucial to examine how therapists perceive and respond to such attitudes. Therapists were therefore asked about their expectations of their clients. Each of the five therapists appeared to have a different set of expectations about their clients.

‘A’ expected clients to understand that psychotherapy does not involve a therapist ‘fixing’ a client’s problems. ‘G’ expected clients to be open. However, she added that she expected different things from clients who came from different cultures, knowing that two people from two different cultural groups would not be exactly the same: ‘If a new Iranian immigrant comes to me, I do not expect the same outcome that I would from a British client who has been exposed to ideas around psychotherapy from infancy.’

‘R’ expected clients to collaborate with him and gradually to become capable of breaking away from their internal restrictions, some of which may be obstructing their happiness. ‘S’ expected her clients, especially those of Iranian descent, to cooperate and to listen to her advice. ‘L’ was interested in the psycho-educational approach, because it provides clients with more knowledge about psychotherapy.

Thus, therapists are interested in clients' need to approach psychotherapy as a shared endeavour, in which both therapist and client play a role in the successful outcome. Whalen and Zimmerman (2007) discuss this, noting that psychotherapy does not involve ‘advice-giving’ sessions, in which therapists tell clients what to do. Rather, psychotherapy is a problem-solving process involving both therapist and client.

### ***7.10 Approach of the Therapist to the Therapy Sessions***

Therapists were asked specifically about their approach to the therapy sessions. Question 11, 12, 13 and 14 are thematically presented below.

### ***7.10.1 Standardisation of Approach for all Clients***

Therapists saw clients from different cultural and educational backgrounds, and were thus asked if they use a standardised approach for all clients. ‘A’ explained that he tries to be as general with all clients as possible. However, when the need arises, he changes his approach by treating each client according to approach most suited to them. ‘G’ ‘use[s] a systematic approach for all people from different cultural backgrounds,’ one related to her willingness to help all clients gain insight in psychotherapy, by gradually learning what is right for them and becoming more able in its application. ‘R’ indicated that he has always been careful about individual differences and considers that his approach may easily offend sensitive clients. He varies his approach to achieve this aim, taking into account what is suitable for each client. ‘S’ takes care to remain open-minded, and respectful of religious beliefs and other cultural issues. ‘L’ reports that she follows established CBT principles, which emphasise the impact of various situations on the life of an individual.

It is apparent from the therapists’ responses that most of them conform to what has been discussed in literature in terms of the psychotherapeutic approaches most commonly used. Wierzbicka (2009), amongst others, has advocated the need to vary one’s therapeutic approaches in ways suited to each client.

### ***7.10.2 Structure of Client Sessions***

Apart from the general psychotherapeutic approach adopted, the structure of sessions also influences how therapists work with clients’ individual differences



(Terasaki 2004). Therapists were asked about the way they structure their sessions to address individual differences, including clients' work schedules. 'A' stated that he tends to use an organised structure, indicating times of the day and days of the week at which they will be meeting. A similar structure is used by 'G', whereby she plans the most appropriate times of day and days of the week to meet with her clients, taking into account convenience for the clients. She further indicated that, 'in line with the systematic approach that I use, I explain the approach thoroughly to clients, and particularly emphasise the need to have a well-structured session.'

'R' emphasises the importance of frequency, when it comes to structure. He uses either an intensive psychotherapy structure, in which all family members are given therapy, or a semi-intensive structure focusing on an individual, according to the clients' needs. 'S' employs sessions with a flexible structure; clients are afforded a lot of space to decide for themselves the manner in which they want to structure their time with her.

'L's approach differed from that of 'S', as 'L' strictly follows the CBT approach and structure. The approach of 'L' does not conform to that emphasised by Terasaki (2004), as the author suggested that when dealing with multi-cultural clients, unstructured sessions must be used to meet their individual needs. Unstructured sessions confer variety on one's psychotherapeutic approach, enabling individual client needs to be met.

### ***7.10.3 Factors that Suggest the Need to Close Sessions***

Psychotherapy sometimes ends abruptly; sometimes clients remain in psychotherapy until its logical conclusion. In cases where the clients stay until the end of

their sessions<sup>7</sup>, therapists consider certain factors when deciding when to terminate sessions.

In the literature, these are referred to as client-based and therapist-based factors (Turner 2012). Vehvilainen (2003) and Sudnow (2007) argue that client- and therapist-based factors are of equal merit. Some therapists gauge their clients' degree of maturity to determine whether they are in a position to know the point at which they will no longer require sessions. Once clients can be trusted to make the right decision in this regard, it is best if they make this decision themselves. Nevertheless, it may be argued that therapists are in the best position to make this judgement on the basis of their professional experience,

#### *7.10.4 Therapists' Definition of a Successful Therapy*

Interviewees were asked whether thought it necessary to take account of the cultural needs of their clients and try to address these directly in the course of therapy. Sudnow (2007) noted that, since clients approach therapists with different issues, it is unrealistic to expect all therapists to use similar parameters to determine the success of a session.

'A', 'S' and 'G' all stressed that when a client begins noticing an improvement in their life, it marks the point at which they can start considering their sessions successful. 'R' emphasised clients' ability to identify solutions on their own, through the course of therapy. 'L' said, 'given the fact that not all clients are able to complete the entirety of the

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<sup>7</sup> This refers both to clients staying for the duration of particular sessions and for the duration of overall psychotherapeutic treatment.

CBT sessions, a successful therapy is one in which the client is able to stay through to the end of the whole session.'

## **7.11 Culture-Based Training**

### ***7.11.1 Therapists' View on Additional Training***

Interviewees were asked whether thought additional training in the context of working with Iranian clients would be useful. All five therapists were unanimous in their agreement, corroborating literature on the changing face of psychotherapy, which needs to be met with refresher courses for therapists (Vehvilainen 2003) . 'G' drew attention to the fact that there are always new trends in the profession and that one needs to be aware of these. Therefore, she always feels open to extra learning so as to promote her competence. 'R' agreed with Turner (2012), who discussed the fact well trained therapist's foster greater trust and have more successful encounters with their clients.

### ***7.11.2 Reception of Culture-Based Training***

The need for culture-based training was also unanimously recognised. All respondents admitted that receiving additional culture-based training would be helpful for their profession, to ensure that they are better positioned to work with clients from different cultural backgrounds. Almost all respondents had already received some level of culture-based training. 'R' was the only therapist who had not received formal training in cultural issues; he believed that some culture-based training would be very helpful for his practice. He had previously stated that his approach is not culturally congruent, and was

conscious that culture-based training could enhance his competence in meeting the demands of culturally-diverse clients.

‘A’ said, ‘even though culture-based training is very important, a therapist cannot learn about all the world’s cultures.’ The best form of culture-based training for him was thus based on what is learned by therapists during sessions with a variety of clients. Szymanski (2009) noted that culture-based training is important but is most effective if carried out by a therapist who acutely recognises the need to learn about a particular culture, usually when he is currently working with a client from a particular background.

#### ***7.11.3 View on Current Available Culture-Based Training***

Szymanski (2009) studied most forms of culture-based training models for psychotherapists, arguing that they may in fact promote cultural disintegration, i.e., and the division of society into groups based on cultural affiliations. To explore this idea, interviewees were asked if they agreed with this notion, and whether they thought therapy sessions should be approached from a cultural or a ‘traditional’ perspective. Respondents did not agree that culture-based training influences therapy sessions negatively. ‘S’ stressed that culture-based training can help therapists develop a better understanding of their clients. In this manner, therapists may be better equipped to meet clients’ needs.

#### ***7.11.4 Contribution of Therapists to a Country-Targeted Culture-Based Therapy Programme***

All respondents considered a country-specific (in this case, Iranian) culture-based therapy training programme as an opportunity to support to their Iranian clients better.

They considered it a good initiative, and one, which may help UK Iranians. They were ready to commit to this programme and to contribute towards it. This confirms the position of Terasaki (2004), associated with the role played by practitioners in the country of their practice to help immigrants lead a better life.

## 7.12 Interview Analysis

### 7.12.1 Findings

<b>Data Analysis</b>	June	Using content analysis	A comprehensive list of similarities or differences in the culture-based therapy approach used by the interviewees.
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**Table 8: Data analysis**

Qualitative analysis of the focus-group data will now be presented. The aim of data collection was to understanding how effective interviewees consider Western psychotherapeutic approaches for Iranians clients. Data was collected using an interview guide (as described previously), and a comprehensive list of similarities or differences was compiled regarding the culture-based therapy approach used by interviewees.

### 7.12.2 Clients from Iranian Communities

The focus-group asked five psychotherapists about the percentage of Iranian clients they received. Five were interviewed previously (interviews were discussed in the previous section). Respondents indicated that it was difficult to provide an accurate percentage of Iranian couples that attended their sessions. ‘A’ said, ‘I cannot be very certain, but I do not think the number is more than 20%.’ A similar trend was observed from the other respondents; none cited an average percentage in excess of 20%. ‘S’ stated that less than 2% of her clients are Iranian. A follow-up question of ‘A’ to ‘R’ revealed that many factors motivate people to seek psychotherapy. It was difficult to discern why

the percentage of Iranian clients was so low. ‘S’ emphasised: 'I do not think there are as many Iranian couples in my work as compared to those from other nationalities.'

### ***7.12.3 Issues brought by Iranian Couples***

Psychotherapists were asked about the kind of issues brought to them by Iranian couples. According to ‘L’, 'most of the Iranian couples that come here have marital problems.' A similar view was held by ‘R’, who reported that 'most sessions are introduced by the wives, most of them complain about abuse of their fundamental freedom as compared to the freedom enjoyed by wives from other nationalities in Britain,' which demonstrates the dominance of family issues in psychotherapy.

The issues Iranian wives tend to attend therapy for, illustrate the significance of ‘dominant’ versus ‘recessive’: When a person finds herself in a new society, her original cultural sense of belonging will likely be influenced by the new culture, and may gradually become her dominant culture cultures (Muntigl & Zabala 2008). Other issues raised by ‘A’ and ‘G’ was factors associated with the workplace as well as wider difficulties in adjusting to UK culture.

### ***7.12.4 Why Iranian Couples Choose a Particular Psychotherapist***

Even though the number of Iranian couples seeking psychotherapy might not seem high compared to mainstream clients, the reasons for their selection a particular psychotherapist was still investigated. ‘L’ noted that 'most of the Iranian couples that I’ve seen are aware that I have some background in Iranian couple work and so they feel that I

am in a good position to understand their issues from a cultural perspective.' Parallel responses were also given by 'G' and 'S', indicating that the similarities in clients' culture with their Iranian culture might have influenced the fact that they were selected.

These findings strengthen those of Antaki, Barnes and Leudar (2004), who found that, because the principles of psychotherapy require empathy, most clients choose therapists in whom they can best confide. This was confirmed by 'R', who said most clients indicated that other Iranians had recommended his services to them.

#### ***7.12.5 Involvement and Engagement of Iranian Couples in the Psychotherapy Sessions***

It was difficult to gather several responses regarding the level of involvement and engagement of Iranian couples in psychotherapy. For instance, when asked about the level of involvement by these Iranian couples, five respondents emphasised that Iranians did not find Western psychotherapy techniques accommodating; they did not think Western techniques conformed to their cultural principles. 'G' stated that 'the level of cooperation by Iranian couples tends to be very low.' 'R' also attributed this issue to culture, but offered a different perspective: 'most Iranians see psychotherapy as a Western practice and therefore find it difficult to adjust to the process.' According to 'R', this may be one of the reasons Iranian couples do not see sessions through to completion.

Many other issues, such as cultural and linguistic barriers between East and West, compound this problem. Orlinsky, Ronnestad, and Willutzki (2013) argued that because Western psychotherapeutic approaches are informed by Western culture and nuance, generalisation of this approach is difficult and flawed.



### ***7.12.6 Role of Clients' Ethnicity in Client Engagement***

Respondents were asked about how clients' ethnicity influences their engagement with therapy. 'S' said, 'I believe that the client's ethnicity can affect engagement. Clients from cultures where sexual intimacy is regarded as a sacred topic, may find it difficult to be open and engaged when it comes to discussing sex.' 'A' mentioned previously that most issues brought by Iranian couples as 'family issues' can be traced back to sexual issues.

Seligman (2010) has argued about the need for culture-based psychotherapy to ensure that each person receives a form of psychotherapy corresponding to his or her ethnic and cultural background; this idea is relevant to the material. It may be argued that there should be a specialised culture-based psychotherapy to address the ethnic differences of Iranian couples. Such an approach may promote better ways of helping couples to be expressive in terms of their sexuality and other sensitive topics (Searle 2009).

### ***7.12.7 Psychotherapeutic Approach Used by Respondents***

The type of psychotherapy used by the majority of interviewees was CBT. CBT is a well-structured Western approach involving a list of tasks and activities that may be used by psychotherapists with clients (Antaki, Barnes & Leudar 2004).

Therapists who used CBT also employed other Western approaches, and they used similar psychotherapeutic approach for all clients. Only 'A' emphasised, 'I sometimes try to vary my approach and not to be dogmatic with clients.' This more open

style is supported by Seligman (2010), who considers it important for psychotherapists to identify individual differences and to vary their psychotherapeutic approach.

#### ***7.12.8 Closure of Sessions***

When asked which outcomes are considered essential before bringing psychotherapy to a close, most respondents said they would always seek improvement in the issues brought to them by the clients, before deciding sessions should end. Unfortunately, as noted by 'G', 'It is disappointing to notice that most Iranian couples can feel dissatisfied at the point of closure of the sessions because their issues are not solved by Western therapeutic approaches.' This suggests that using Western approaches to psychotherapy for Iranian couples have its limitations. It was noted by 'R', 'S' and 'L' that sessions with Iranian couples often end abruptly, related to 'R's statement that 'they can feel disappointed when they realise that I am not applying any cultural dimensions to their issues, as they had heard before we stated the programme that I had an Iranian background.'

#### ***7.12.9 Rate of Success with Iranian Clients***

Since most Iranian couples tend to end psychotherapy abruptly and consequently do not feel very satisfied with the outcome, the respondents stated that their rate of success with most Iranian couples was low. For instance, 'A' stated that 'when I did a follow-up with the Iranian couples I had been seeing, I found that most of them were back at where they had been before.'

In terms of the importance of feedback in psychotherapy, 'S' (2009) noted that feedback is achieved mostly through follow-ups; a psychotherapist must follow-up so that they are aware of the rate of success he or she has with clients. Indeed, many other respondents noted low rates of success with Iranian couples, blaming them on the lack of compatibility between clients and psychotherapeutic approach. It is important to note that the deciding factor in the therapist's rate of success seems to be dependent on the therapeutic approach used rather than on the therapist's cultural background (Rober et al. 2008).

#### ***7.12.10 Need for Additional Training to Cater for Culturally Different Clients***

As discussed above, respondents were asked about the need for additional training to cater to cultural differences among clients. All of them agreed that culture-based training would be helpful. This thinking was based on their experiences with clients, referred to by 'S' as 'minor cultures'.

As stated in the literature, the need for additional training is important so that therapists can meet the specific needs of clients from different cultural backgrounds (Scollon 2009). 'R' stated that 'the specific needs of clients are many and it is only when psychotherapists have some idea about what each person expects that they can make the best out of their sessions.' 'R' may appear to have a different view regarding CBT; however, he refers not to cultural differences but rather to the differences between the needs of people, from a psychological point of view. He does not take into account their nationality or culture.

All interviewees indicated that they would like to contribute towards the development of comprehensive, country-specific, culture-based therapy programmes.

#### ***7.12.11 Introduction of the Researcher's Psychotherapy Programme***

Both the literature and the interviews provide evidence for the dissatisfaction of Iranian clients with Western psychotherapeutic approaches, and it was therefore felt that a new culture-based psychotherapy programme merits development, by updating the Psycho-Educational Programme (PEP) already used by the researcher in her practice. This programme helps psychotherapists better understand client's needs.

A focus group discussion was held to discuss and even critique the development of this programme. The findings of discussion are summarised into a Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis for the existing PEP.

#### ***7.12.12 Strengths of the PEP***

After going through the PEP with respondents, they were asked about the strengths of the programme based on the things that the programme was good at. They were asked to highlight the ways in which it could represent a good alternative to other available approaches. From the responses received, the programme's interactive nature was mentioned as a major strength. PEP seeks to engage the client. Muntigl and Zabala (2008) indicated that when psychotherapy sessions are conducted interactively, clients consider themselves stakeholders in the programme. Therefore, PEP can be seen as

having the ability to make clients assume part of the responsibility for the success or failure of the sessions, helping them become fully involved.

The discussions in the focus-group also demonstrated the strength of PEP in terms of cultural bias. In PEP, psychotherapists are expected to have enough knowledge about their clients' culture, implying that their approach to therapy will vary from one client to another based on the cultural framework of each client. Orlinsky, Ronnestad and Willutzki (2013) advocate a culture-based psychotherapy that varies its approach to suit the individual needs of clients and this idea is followed by the PEP. This contrasts it with CBT, which uses a more rigid approach that is the same for all clients.

#### ***7.12.13 Weaknesses of the PEP***

The weaknesses of the PEP were also mentioned by respondents, and represented things that the programme addressed incompletely, thus making other approaches preferable in this regard. The first issue was related to the fact that the programme is very cumbersome. Nelson-Jones (2011) has observed that most cases of psychotherapeutic assistance must be considered as emergency cases requiring urgent attention. Therefore, when comparing PEP to CBT and person-centred approaches, it can be noted that the latter are more straightforward and do not require major changes in the structure of sessions.

One respondent also mentioned the issue of the PEP, confusing a culture-based approach with a multi-culture-based approach. The respondent said, 'I find you talking about the fact that PEP helps clients to understand the question of multi-culturalism

rather than to reject it. At the same time, you advocate that psychotherapists should approach each client focusing on his or her cultural background.' This opinion, namely that the PEP may possibly confuse culture-based psychotherapy with multi-cultural psychotherapy, also exists in the literature. Culture-based approaches focus on the provision of culturally-competent psychotherapy to the clients. Conversely, the focus of multi-cultural psychotherapy is to provide psychotherapy that encompasses aspects of all the cultures. In this way, the psychotherapist is not obliged to change his approach for different clients. This is because each client will be presented with something that is aligned with his or her own culture (Barnes & Moss 2007).

#### ***7.12.14 Opportunities Provided by PEP***

Another area discussed were opportunities the programme presents to clients. The question of opportunities was concerned specifically with the issue of professional conditions that can improve its use. It was mentioned in the group that PEP takes a multi-dimensional approach and that it is a good opportunity for professional practice. Moreover, it accommodates approaches such as role-play, group discussion, workshops, seminars, and one-to-one sessions (Pereplechikova, Treat & Kazdin 2007). The PEP embraces all of these approaches, making it multi-dimensional. 'R' stated that 'because most of these approaches are already used by psychotherapists, it will not be difficult for them to adapt them so that they can be used for the PEP, as these multi-dimensional ways of working won't be new to them.'

As exemplified in the interviews, most Iranian couples appear to want an approach that can accommodate their cultural differences, making it possible for them to confide in therapists. The PEP satisfies this requirement through its cultural provisions. This can make the programme acceptable not only to psychotherapists but also to clients, especially those from minority cultural backgrounds.

As stated by the Mental Health Foundation (2011), ethnic minorities are more likely to have poor outcomes from treatment; hence, they disengage more easily from mainstream mental health services. This alarming fact is addressed by the PEP that was developed.

#### ***7.12.15 Threats to the PEP***

The issue investigated lastly in the focus-group was related to factors and conditions that may threaten the success of the PEP. If these conditions are not addressed and the therapist does not respond to them proactively, the programme itself will be threatened.

One such threat refers to situations in which clients do not understand the difference between the therapist's background and his or her approach. For instance, it was reported by 'L' that, 'for most clients, once a therapist is seen to be from a Western background, he or she is assumed to be using a Western approach.' Thus, it can be challenging for clients to know that it is still possible for a therapist with the PEP to be from a Western background, but to adequately facilitate a psychotherapy session capable of addressing all the client's cultural needs.

Another perceived threat was observed by 'A' who stated that 'Iranian clients are yet to accept that the therapist is a facilitator and not a problem-solver.' The PEP adopts the principle that the therapist must act as a guide as well as a leader only initially, and then gradually must empower the client. The common situation in which the client sees the therapist as being ineffective of not offering outright 'solutions' is unavoidable up to a point. However, the more information the client has about the therapist they will visit, including their area of expertise, the better. This includes an understanding that the therapist is someone who can help, but cannot solve his or her problems. This information should be given to clients before they visit a therapist. Particularly, when it comes to Iranians, they may be helped by being encouraged to find out more about psychotherapy before commencing treatment.



## **CHAPTER 8: RESEARCH VALIDITY, RELIABILITY, AND ETHICAL CONSIDERATIONS**

This chapter addresses the validity and reliability of the research. Ethical considerations as related to data collection are discussed.

### ***8.1 Pilot Study***

A pilot study was conducted, which consisted of interviewing one psychotherapist. The therapist practised at one of the centres not included in the rest of the research. This centre was selected with the help of a colleague's social network and through his acquaintance with the manager.

The centre's manager provided the name of the psychotherapist who would be interviewed, and the interview was scheduled on the centre's premises. Informed consent forms were signed by the centre as well as by the psychotherapist before scheduling the interview.

The interview was conducted using a preliminary version of the questionnaire. It was recorded with the respondent's consent. Based on the interview responses and on personal observations in terms of interpretation of the questions by the respondents, judgments were made as to whether the questions elicited relevant responses. It was then possible to modify the questionnaire further.

The pilot study also helped in the realisation that more open and comprehensive responses would probably be obtained with simple, direct questions; by maintaining a

tone neutral throughout the interview; and by employing more follow-up on questions. The pilot study helped fine-tune the research instrument, and helped the researcher develop and practise her interview skills.

## **CHAPTER 9: PRODUCTS AND IMPACTS**

This chapter presents the anticipated outcomes and impacts of this project on various aspects of the researcher's experience and clinical practice. Future directions for research are explored.

### ***9.1 Research Product***

Research outcomes refer to what one hopes to achieve from a study. In this case, what will the impact of the above findings be on the way psychotherapy can be applied to clients from Middle Eastern backgrounds? The hoped for outcome is a better understanding of the mental health care needs of Iranians who have immigrated to the UK. By understanding the impact of cultural and religious factors on how therapists approach issues, for example, sexual issues, with these clients in therapy, it is hoped that the standard of mental health care offered to these patients may be improved; indeed, that therapists from different cultures may better be able to help and support such clients. The outcome is an evaluation and validation of, and improvement on, the Psycho-Educational Programme previously developed.

The main product of this thesis will be a series of seminars and workshops, which aim to assist clients from culturally diverse backgrounds. It is hoped that those who need therapy as they encounter a Western culture alien to that of their homeland, will be helped by therapists with a better understanding of how to translate Western therapeutic practice to a Middle Eastern, and specifically to an Iranian, context. The researcher's

multi-lingual background prompted her to realise that psychotherapy based on culture can be more effective to support these families, and Western society at large. The hope is that therapists with cultural knowledge will be in a strong position to guide families in adjusting to their new Western environment.

The outcome of this thesis will be improved weekly weekend workshop seminars designed for group psycho-educational therapy. The seminars will use lectures, role-play and group discussions to challenge perceptions and cultural outlooks, and to provide education in changing paradigms. The foundation of these seminars is an acknowledgement that cultural, ethnic, religious, educational, familial and other psychosocial differences between the client and the therapist play a crucial role in the efficacy of the therapeutic process. It is hoped that by acknowledging and investigating the way these differences impact on therapy, as this thesis has set out to do, will enhance the quality of the therapeutic service offered to such clients.

These seminars will be designed based upon the current research findings, as well as on evidence from the empirical literature on conducting psychotherapy across the cultural divide. Existing evidence on the psychotherapeutic needs of immigrants was examined in order to locate areas for further examination. The current research findings will provide further insight into these issues. It is hoped that properly reviewing the literature in this way, as well as adding to it with the current empirical findings, will lead to an improved, empirically supported seminar structure. In designing these seminars, therefore, the following was drawn upon: the researcher's professional experience as a

psychotherapist; existing theories on the need for specialist psychotherapy, when working with culturally-diverse clients; the professional experiences of the psychotherapists who participated in the research, in terms of their work with Iranian immigrant clients in the UK; and the research findings from the perspective of the clients' experiences.

The first portion of the seminar consists in the 'check-in' process, and involves encouraging clients to talk about their feelings and issues. Talking openly is still taboo in Iranian culture. In my work with these seminars to date, I have found it useful to encourage Iranian clients to talk openly in front of other members. Encouraging these clients in a gentle, empathic way often makes them less reticent to share their stories. Hearing others talk also helps them realise that many people who share their culture and background also share their problems and suffering. I have found that these check-ins reinforce for members of the seminar group the similarities between their stories and situations, and those of others in a similar situation to theirs. An important finding emerging from the current research, and an overarching theme running throughout the interviewee responses, is that most of the concerns brought to therapists by Iranian clients are related to cultural issues.

This will be important in refocusing the check-in portion of the seminars, and will allow therapists to reassure clients that they are aware that cultural adjustment issues are a main concern, and that they are there to facilitate working through such issues. Interviewees as central to their expectations of therapy expressed the need for cultural acceptance. Knowing this will allow therapists conducting the seminars to emphasise cultural acceptance of the clients attending. This may reasonably be expected to facilitate all that follows in the therapeutic process, by encouraging clients to open up more readily and to explore their issues with less inhibition.

The medium of acting allows powerful dissection and exploration of characters and roles, perhaps more so than creating a reading checklist. Because of this, the second part of the seminars thus far has incorporated an acting element. During the seminars, clients are assembled into acting groups. As the facilitator, I then direct the acting members to explore and portray all conflicts and issues pertinent to them—especially cultural issues—through drama. Seminar members are invited to participate. This has proved to be a very popular and enjoyable aspect of the seminar, and thus became integrated in the weekly schedule for the seminars. After the acting out exercise, I analyse the drama for the clients, from psychological, sociological and political points of view. During this analysis, I attempt to deconstruct Middle Eastern cultural taboos. I involve participants themselves in deconstructing these taboos, by talking as openly and honestly as possible about taboos, and by using role play. I realised that by presenting pertinent issues in the context of scenarios in which clients can readily picture themselves as actors, they learn more. Students of all ages and social classes take part in and benefit from such role-playing and dramatic acting out of daily, topical household events. This learning medium has proved vastly beneficial in that it allows seminar members to see potential ways of dealing with such situations, and the consequences such actions may have, by seeing the actors project these. A large variety of issues may be addressed in this way, ranging from marital problems, family issues and cultural conflicts, to mental health issues such as depression, Obsessive-compulsive disorder, anxiety, internal and external conflicts, addictions, and so forth. According to the current research, issues of social anxiety and social isolation are amongst leading concerns to such clients, suggesting that

these would be fertile topics to be acted out during the role play portion of the seminars. All of the issues raised by interviewees during the data collection phase of this research would present suitable starting points for scenarios to be acted out.

The third part of the seminar consists in a lecture. It is interspersed with small workshop group discussions. Based upon findings in the current study, common issues faced by Iranian clients include relationship problems, being a victim of torture, everyday coping and family issues, as well as issues of social class, infidelity and sexual problems. The prominence of these issues as raised by the interviewees argues for making these a central point of focus for the lecture and discussion group portion of the seminars, as well as useful topics for role play. The strength of the improved seminar outcome will hopefully be that the themes held to be most central, as emerged from the findings, can be used as common threads running throughout each aspect of the seminars, in the hope of making them more cohesive and practically useful.

An important aim of the seminar, reinforced by the new data, is to help Iranian clients accept their new culture in the UK, by discussing and examining their fears. They are often confused about their culture and belief systems after immigration, which causes conflict for new generations in the family. It may be instructive to include an educational portion in the lecture component of the seminar about the extent to which couples' ability to achieve cultural integration impacts on successive generations of the family. Again,

these issues could be addressed through role-play, as well as highlighted as important during check-in.

Each seminar topic is discussed and addressed over a number of weeks. Once yearly, the weekend seminar is held outside of London. Seminars are held during the day, and social events are scheduled for the evening. Encouraging socialisation amongst the clients in the group helps reduce their anxiety and depression. Given the prevalence of social isolation mentioned throughout the interviews, this will likely be a worthwhile aspect of the seminar to carry forward for the improved version of the seminar.

### ***9.2 Potential Impact of Research and Final Product on the Profession***

It is believed that the research undertaken towards this doctoral degree has the potential to impact on the field of psychotherapy and to bring about change, particularly amongst for clients from culturally diverse backgrounds. In terms of seminars, they have the potential to help other psychotherapists regarding the need for culture-based psychotherapy, so as to minimise disengagement by these clients. The seminars may also motivate psychotherapists to undergo further training in culture-based issues, so as to provide more effective psychotherapy. This project has asked and attempted to provide some answers to questions that might form the basis for future research focusing on other cultural communities.

This project has tried to identify factors that necessitate culture-based training for therapists. This raises questions such as: What is the best therapy for culturally diverse clients? It is essential to understand the need for culture-based therapy because the rate of



immigration has increased globally, leading to vast cultural heterogeneity, particularly in countries such as the UK. This research recognises areas in which significant differences exist between commonly used approaches and those of culture-based psychotherapy. This might enable psychotherapists to undergo further training but may also facilitate those seeking therapy to make more informed choices. These differences are vital in minimising the rates of disengagement of culturally diverse clients. However, this research does not suggest that identifying these differences in itself guarantees successful outcomes.

## **CHAPTER 10: CONCLUSION**

The researcher's experience as an integrative psychotherapist working in the fields of couples', psychosexual and family therapy for over fifteen years, has enabled the identification of the need to develop a psychotherapy programme to address the needs of Iranian immigrant couples in the UK. As shown previously, Middle Eastern culture has been researched, including the study of Middle Eastern languages and politics for the past twenty-seven years. The MEFCE, at which the researcher worked from 2004 until 2010, was created on the basis of this knowledge. Similarly, weekly seminars and workshops in private practice have been run since 2007, in addition to the FPEP weekly participation in television or live radio programmes. The researcher is therefore well acquainted with the pressures faced by immigrants.

The significant rise in the Iranian population in the UK makes the need for culture-based psychotherapy for this group ever more present. Immigrants may face specific mental health pressures and may experience high levels of stress and conflict surrounding issues such as the fear of being introduced to a different culture and religion as well as the fear of losing their identities. In this project, methodologies related directly to Iranian immigrants were used. The different approaches were based on the researcher's own experience with her own Iranian clients. Detailed interviews with other psychotherapists, who have also worked with Iranian clients for a period of time, were also conducted.

Several cultural psychotherapy models have been used. These include La Roche's three-phased cultural psychotherapeutic model (La Roche 2013), the formative method for adapting psychotherapy (Hwang 2009), culturally responsive CBT (Hays & Iwamasa 2006), the cultural relationship model (Pedersen, Crethar & Carlson 2008; Pedersen 2004), clinical multi-cultural reality therapy (Tseng 2004), and the cultural adaptation model (Smith Rodriguez & Bernal 2011).

Most of the psychotherapists interviewed were dissatisfied with the high rate of disengagement of their Iranian clients. Their success rate with Western clients seemed to be higher than with their Iranian clients. It is assumed that most people disengage from therapy due to lack of understanding. Consequently, they are less likely to accept the constituents of therapy. It may also be due to a lack of understanding on the part of their therapist in terms of clients' culture, as well as a fear of being judged by the therapist. Finally, disengagement may be the result of feeling unable to be expressive in terms of sexual issues. In particular, most Iranian women receiving therapy were identified as being uncomfortable when talking about sex in the presence of their husbands.

It is also clear, both from this research and from the researcher's clinical experience, that most clients tend to be uncomfortable with therapists who cannot approach sexual issues from a cultural perspective: the perception of Iranian clients appears to be that the therapist is meant to 'fix' them. Thus, factors such as religion and education have an immense impact on clients' engagement as well as on their expectations of therapy. The interviews clearly demonstrated that clients feel a strong need for social acceptance.

As discussed earlier, one of the main issues faced by Iranian immigrants is their sense of cultural shock. Encouraging them, as part of collaborative working, to pursue an active social life, may ease this. In the FPEP programme, for instance, clients are encouraged to join a private Facebook group, through which they may update their progress. All members are encouraged to attend parties and to invite one another to these events. An annual trip is organised outside London for two nights, during which all members stay at a hotel; two seminars and two private parties in the evening are also arranged including a talent show (see Figure 5 below). These events help reduce anxiety, cultural conflict and other issues faced by clients. The aim of the seminar trip weekend is to join as a family, in order to get closer to each other and to join the seminar sessions in a different environment. I also encourage the members to exhibit their new hobbies, therefore, providing a platform such as the FPEP talent show for the members to portray their talents is an important element of the seminar.



The poster for the FPEP Seminar Trip 2014 features a central image of a large, leafy tree in front of a modern building. Above the tree, there are two smaller images: one of hands holding a small plant and another of fireworks. The text is in both Persian and English.

**FPEP سمینار**  
**The weekend FPEP Seminar Trip /2014**  
**Alexandra House hotel ★★★★★**

Dear all, good news! FPEP weekly seminar has organized another weekend trip on **2014** at the **Alexandra House hotel 4\*** for 2 nights & three days with 2 seminar's & 2 private party at nights including live Iranian, Arabic & Western music & entertainment. Breakfast & dinner included. For more information & reservation contact Mitra Babak 07984414545 or Frozan 07449472314 **ASAP**

دوستان و یاران عزیزم : به اطلاعاتان میرسانم سمینار هفتگی مجدداً یک مسافرت آخر هفته را برای شما و خانواده در تاریخ **22014** در هتل چهار ستاره الکساندرا برای دو شب و سه روز با صبحانه و شام با امکانات کامل سبا در هتل تشکیل داده است که شامل 2 سمینار و 2 پارتنی خصوصی با موسیقی زنده ایرانی و عربی و غربی میباشد . برای اطلاعات بیشتر و یا رزرو جا با میترا بابک با شماره **07984414545** و یا فروزان با شماره **07449472314** تماس بگیرید . ( به علت محدودیت جا خواهشمندیم هر چه زودتر تماس بگیرید . با سپاس میترا بابک

Thanks Mitra Babak

Figure 5: FPEP Annual trip

This dissertation has examined the need for therapists to undertake additional training to promote their competence in culture-based issues. Culture-based training is considered helpful to the profession, and may strengthen the position and efficacy of therapists when working with people from different cultural backgrounds. Clients may feel embarrassed if their issues contradict their culturally conventions. For instance, Iranian clients often have profound difficulty disclosing sexual issues, particularly to people who do not share their cultural understanding. As mentioned, most female clients find it difficult to talk about sexual issues when their husbands are present. It has been

established that there is a need for therapists to try and approach clients from a cultural perspective, to make them feel more comfortable.

In particular, Iranian clients perceive psychotherapy as a practice meant to 'fix' them. Therefore, clients expect the therapist to provide detailed guidelines and solutions during therapy. Most Iranian clients do not understand the Western psychotherapeutic process. Hence, it is important to enlighten clients through seminars about what to expect from the process.

Culture-based therapy, which takes account of factors such as ethnicity, education and approach, is imperative (Zimmerman & Whalen 2008). These factors should be considered in promoting better engagement.

This research has established that there is no standardised approach that can be used among clients from culturally diverse backgrounds. Therapists vary their approaches. Some are open-minded about cultural issues; others demonstrate caution in terms of their religious and cultural beliefs. The researcher believes that there is scope for a variety of approaches to better meet, in each particular case, the needs of a client, so as to cater for all cultural differences. The culture-based approach is flexible by incorporating methods used by different psychotherapists. In addition, a good structure is of course essential and smoothes the therapeutic process. The manner, in which psychotherapy ends, also depends on the particular therapist and client. It is important that clients are consulted on this decision, and of course the professional experience of the therapist is significant in deciding when therapy ends.

Culture-based therapy may lead to more successful psychotherapeutic experiences for clients, and may better assist them with their problems and daily lives. This includes the ability to remain in therapy for the entirety of the planned treatment. Based on the existing research findings, there is a pronounced need for additional therapeutic training, so that therapists may acquire further skills to assist them in fulfilling the needs of clients from different cultural backgrounds.

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## APPENDICES

### My Background and Media Coverage

Weekly Satellite Persian International TV/Live Radio

BBC Persia: Post Natal Depression

Articles for Iranian International Newspaper

# Mitra Babak

Specialist Consultant Psychotherapist and Researcher

#### F.P.E.P. Seminar

First Three Sundays of the Month  
Times: 12:00 16:00  
Nadi Park Royal  
260 Old Oak Common Lane,  
London NW10 6DX  
Email: [infomitrababak@gmail.com](mailto:infomitrababak@gmail.com)

#### For 1:1/Family Therapy

Mobile:  
0044 798441 4545  
Telephone  
0044 208 575 1679

#### Every Tuesday on Radio Omide Iran

At 18:00. London time To ask a question, call  
At 19:00. Sweden Time 'Radio Omide Iran'  
At 21:30. Iran Time 0046 858 410101  
Website: [www.omideiran.se](http://www.omideiran.se) 0046 853 025625

Email: [Info@Radioomideiran.se](mailto:Info@Radioomideiran.se)/[infomitrababak@gmail.com](mailto:infomitrababak@gmail.com)

#### Every Thursday on Radio Azadegan

At 17:15. London time To ask a question, call  
At 21:30. Iran Time 'Radio Azadegan'  
Frequency W3C 0046 858 410101  
[www.radio-azadegan.com](http://www.radio-azadegan.com) 0046 853 025625

#### The Babak Foundation

[www.thebabakfoundation.com](http://www.thebabakfoundation.com)  
[info@thebabakfoundation.com](mailto:info@thebabakfoundation.com)

#### Every Monday Manoto+

At 18:00. London time  
At 21:30. Iran Time  
Website: [www.manoto1.com](http://www.manoto1.com)

Mitra Babak Website: [www.mitrababak.com](http://www.mitrababak.com)  
Facebook: [www.facebook.com/Mitrababakpage](http://www.facebook.com/Mitrababakpage)  
Twitter: @MitraBabak



Mitra Babak



F.P.E.P. Seminar



Lectures



Manoto +

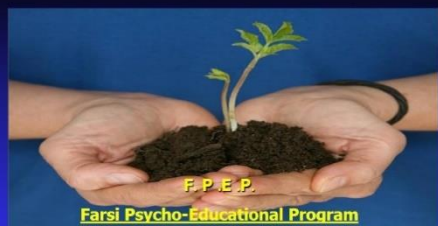


The Babak Foundation

#### Media Affiliates



## FPEP Group Contract



## سمینار هفتگی

به کلاسهای روانشناسی خوش آمدید

Welcome to Farsi Psycho-Educational Program (FPEP)

## Group Contract

## قرارداد کلاسهای روانشناسی

- 7- Positive and supportive attitude
- 8- Open to challenge
- 9- Respect & Acceptance
- 10- Focus on self
- 11- Active listening

- 7- برخوردی دوستانه و صادقانه با خود و دیگران
- 8- چالش و یادگیری از یکدیگر
- 9- تصمیم بر احترام و پذیرش خود و دیگری
- 10- تصمیم بر خود نگری، خوش بینی و احساس امنیت به خود و دیگری
- 11- آموزش هنر گوش کردن و با هم صحبت نکردن

## Group Contract

## قرارداد کلاسهای روانشناسی

- 12- Honesty & Openness
- 13- Accept criticism
- 14- Commitment to change through new learning
- 15- Switch off mobile phones
- 16- Children are permitted

- 12- تصمیم بر شجاعت داشتن و بی پرده صحبت کردن
- 13- تصمیم بر انتقاد پذیری
- 14- تصمیم بر پیاده کردن تمام آموزشی که در اینجا یاد میگیریم در عمل
- 15- خاموش بودن تلفن موبایل
- 16- از پذیرفتن اطفال معذوریم



Please respect the boundaries, contacting the therapist outside working hours is not professional (Therapist is not A & E)

خواهشمندم به مرز و حدود بین روانکار و مراجع احترام بگذارید، تقاضای حمایت و کمک خارج از ساعات کاری، حرفه ای نمی باشد (روانکار اورژانس نیست)

## استراکچر جدید سمینار

## New Seminar Structure

- Start sharp at 12.00pm
- One word check in
- 30 minutes deeper check in for who wants
- 1.00pm Start Topic & workshop
- 2.00pm Break
- 2.15pm Drama Therapy & feedback
- 3.00pm Psychology Education Re: Topic & workshop

- \* شروع سمینار رأس ساعت 12
- \* چک این با یک کلمه
- \* 30 دقیقه چک این برای کسانی که میخواهند
- \* 1.00 شروع تاپیک و ورک شاپ
- \* آنتراکت 2.00
- \* 2.15 تأثیر درمانی و فید بک آن
- \* 3.00 درس روانشناسی و ورک شاپ

موضوعاتی که در کلاسهای روانشناسی استفاده میشوند به قرار زیر میباشد:

## Psycho-Educational Structured Program

- 1- Beginnings Incl. Group Contract
- 2- Self-Awareness
- 3- What is self-esteem & self-confidence
- 4- Cultural Conflicts
- 5- Understanding Conflict (Internal/External)

- 1- قرار داد گروه
- 2- خودشناسی
- 3- حرمت نفس و اعتماد بنفس چیست؟
- 4- چگونه میتوان با تضادهای فرهنگی برخورد مناسب کرد
- 5- شناخت و آگاهی از تضادهای درونی و بیرونی (آسیبهای دوران کودکی و تأثیر آن در بزرگسالی)



موضوعاتی که در کلاسهای روانشناسی استفاده میشوند به قرار زیر میباشد:

### Psycho-Educational Structured Program

- |  |                                       |
|--|---------------------------------------|
| 6- Bereavement                           | 6- سوگاری و چگونگی برخورد مناسب با آن |
| 7- What is Depression & who is Depressed | 7- افسردگی چیست و انسان افسرده کیست ؟ |
| 8- Anxiety / Panic Attack                | 8- اضطراب، ترس و وحشت                 |
| 9- Anger management                      | 9- اداره کردن خشم و عصبانیت           |
| 10- Addiction                            | 10- اعتیاد و چگونگی برخورد با آن      |

موضوعاتی که در کلاسهای روانشناسی استفاده میشوند به قرار زیر میباشد:

### Psycho-Educational Structured Program

- |   |  |
|---|--|
| 11- Obsession (OCD)                       | 11- وسواس چیست و چگونه میتوان با آن مقابله کرد |
| 12- Post Traumatic Stress Disorder (PTSD) | 12- وحشت بعد از حادثه                          |
| 13- Sexual / Physical / Mental Abuse      | 13- تجاوزات جسمی، جنسی و روحی                  |
| 14- Self-Harm / Suicide                   | 14- خود آزاری و احساس خودکشی                   |
| 15- Relationship Problems                 | 15- مشکلات در ایجاد و حفظ رابطه                |
| 16- Marital Issues                        | 16- مشکلات زناشویی و برخورد اصولی با آن        |
| 17- Sexuality & Sexual Desire             | 17- مشکلات جنسی                                |

موضوعاتی که در کلاسهای روانشناسی استفاده میشوند به قرار زیر میباشد:

### Psycho-Educational Structured Program

- |  |  |
|--|--|
| 18- Parenting in New Environment             | 18- نقش والدین در جامعه ای که در آن زندگی می کنند              |
| 19- Appropriate parenting skills             | 19- چگونه میتوان فرزندی سالم داشت؟ و روش صحیح تربیت کودک چیست؟ |
| 20- Needs of children as they develop        | 20- نیازها و رشد روانی کودک (از بدو تولد تا 21 سالگی)          |
| 21- Social life skills                       | 21- آموزش مهارتهای زندگی سالم اجتماعی                          |
| 22- Other topics as appropriate to the group | 22- موضوعات دیگری که مورد استفاده کلاس قرار خواهد گرفت         |

## روش پرداخت هزینه سمینار:

### Payment Method

- |   |  |
|---|--|
| <b>£35 monthly (3 weeks) for Couple/Family</b>  | ماهنامه (سه هفته) 35 پوند به صورت پیش پرداخت برای زوج و یا خانواده و 45 پوند برای افراد مجرد |
| <b>Payment in advance Individuals £45 Monthly (3 Weeks) &amp; under 18 &amp; 16:</b>                | ماهنامه (سه هفته) 25 پوند و 15 پوند به صورت پیش پرداخت                                       |
| <b>£25 &amp; £15 monthly (3 weeks) Payment in advance</b>   | برای یک هفته: 20 پوند برای هر سمینار   |
| <b>One week only: £20 for each session</b>  | - در صورت عدم حضور در سمینار به هردلیلی هزینه پرداخت شده پس گرفته نخواهد شد                  |
| <b>- No refunds for paid fees</b>   | - در صورت کنسل شدن سمینار هزینه پرداخت شده به جلسه بعد موکول خواهد شد                        |
| <b>In case of non-attendance</b>  |  |
| <b>- In the event of cancellation of the seminar, paid fees will be offset against next session</b> |  |

برای اطلاع بیشتر لطفا با تلفنهای زیر تماس حاصل فرمایید:  
For more information please contact numbers below:

### ■ Weekly Seminars

- Every first three Sundays of each month

- Time: 12.00-16.00
- Address: Nadi Park Royal  
260 Old Oak Common Lane  
London, NW10 6DX
- Nearest Tube: Willesden Junction (Bakerloo Line), North Acton (Central line)
- Bus: 226, 266

- Contact: Mitra: 07984414545, Frozan: 07449472314, Masod: 07759716516
- Email: mitra\_babak@hotmail.co.uk
- Web: www.mitrababak.co.uk

### سمینار هفتگی

هر یکشنبه از ساعت:

12.00-16.00

آدرس: نکر شده در همین صفحه  
تلفنهای تماس:

میترا:

07984414545

فروزان: 07449472314

مسعود: 07759716516

نزدیکترین آندرگراند:

Willesden Junction

(Bakerloo Line)

North Acton (Central line)

Bus: 228, 266

Free Parking Available

**Annual national weekend Seminar/workshop**



**Weekly Seminar Workshops in London (please find examples from a few sessions)**

**London Weekly Seminar/Workshop**



**London Weekly Seminar/Workshop ( Role play)**



**London Weekly Seminar/Workshop Analyzing Role play**





**International Seminar in Norway**  
**21<sup>st</sup>, 22<sup>nd</sup>, 24<sup>th</sup> and 25<sup>th</sup> August 2013**

## **MS. Mitra Babak Seminars**

**Specialist Consultant Psychotherapist & Researcher**

سمینارهای خانم میترا بابک

کارشناس ارشد روانکاوی و محقق خاورمیانه

**Norway 2013**

### **Stavanger**

Address: Haugesundsgata 27, 4014 Stavanger (Johannes Læringssenter)

Wednesday 21<sup>st</sup> August 17:00-21:00

Thursday 22<sup>nd</sup> August 17:00-21:00

Price: 300 NOK Per Day

چهارشنبه

پنجشنبه

### **Oslo**

Address: Østre Aker vei 90, 0596 Oslo (Siemens Building)

Saturday 24<sup>th</sup> August 12:00-17:00

Sunday 25<sup>th</sup> August 12:00-17:00

Price: 370 NOK Per Day

شنبه

یکشنبه

Norway Mobile: +47 46907847

Email: mbseminar2013@yahoo.com

UK Mobile: +44 7587213377

Facebook: Facebook.com/mitrababakpage

[www.mitrababak.com](http://www.mitrababak.com)



Seminar on Couple therapy and Psycho Educational Programme in Liverpool  
28<sup>th</sup> June 2014

## سمینار تخصصی مهاجرت و تطبیق با محیط



مهاجرت می تواند در بردارنده چالش ها و بحران های متعددی  
برای افراد مهاجر باشد

- این چالشها کدامند و عواقب و مسایل پیرامون آنها چیست؟
- چگونه میتوانیم خود را با این چالش ها و تغییرات تطبیق دهیم؟

**با حضور خانم میترا بابک**

متخصص و مشاور روانکاوی

با بیش از ۲۶ سال تلاش و پژوهشگری در زمینه فرهنگ ،  
زبان ، ادیان و سیاست

برنامه های خانم بابک در شبکه های تلویزیونی (من و تو) و مجازی بسیار مورد  
استقبال قرار گرفته است

**همراه با برنامه پرسش و پاسخ**

**از ساعت ۲ تا ۵ بعد از ظهر تاریخ: شنبه ۲۸ ژوئن ۲۰۱۴**

**Toxteth Town Hall, 15 High Park St., Toxteth, Liverpool, L8 8DX**

ثبت نام: در صورت تمایل به شرکت به یکی از راههای زیر ثبت نام کنید

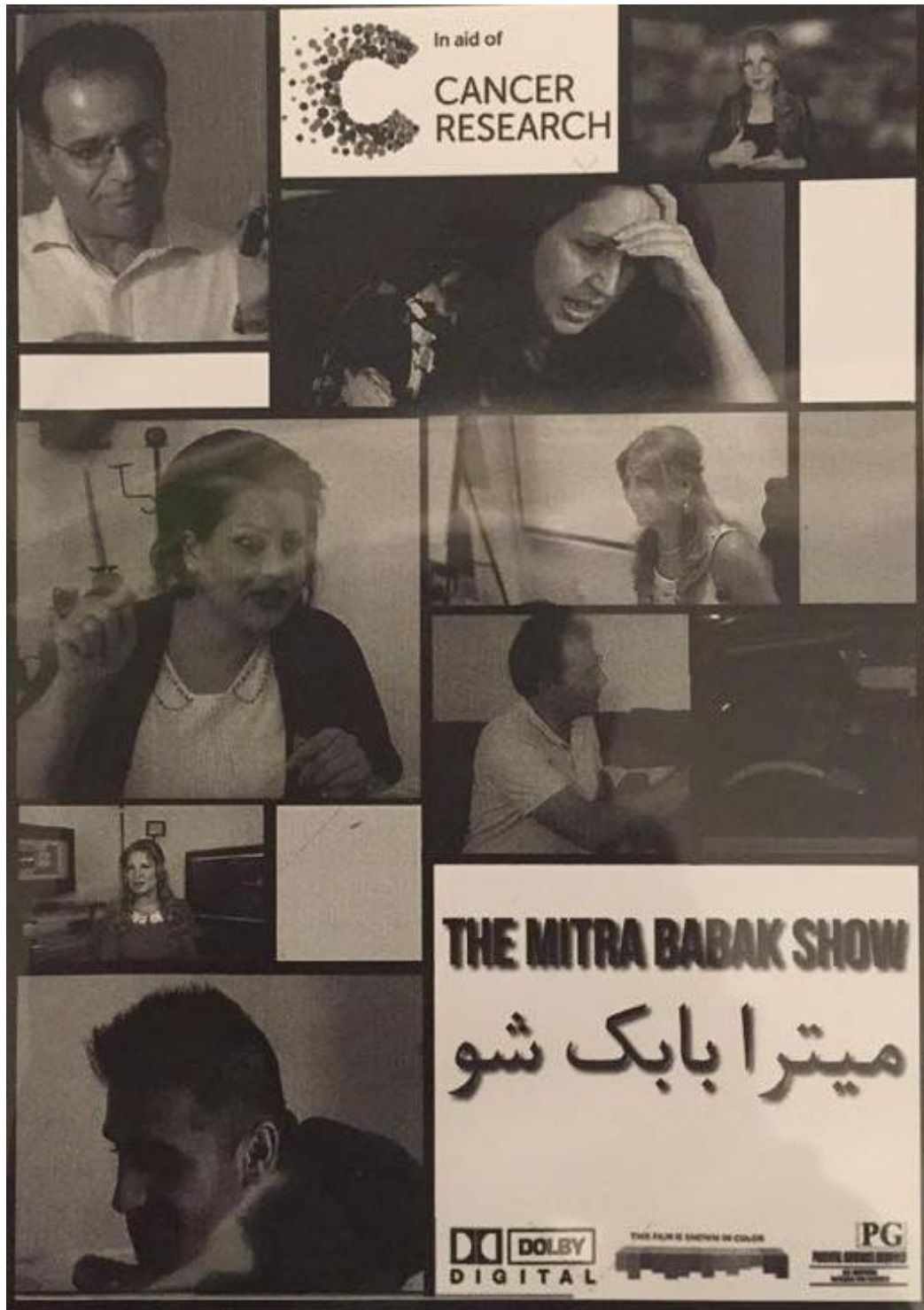
- ارسال ایمیل به [icsl@live.co.uk](mailto:icsl@live.co.uk)

- اطلاع به مسئولین مدرسه فردوسی در روزهای یکشنبه

- تماس تلفنی یا ارسال پیام کوتاه (با قید نام) به یکی از شماره های زیر

۰۷۸۲۵۳۰۲۸۴۸ - ۰۷۴۴۷۹۳۵۴۰۴ - ۰۷۵۷۵۵۵۰۰۳۹ - ۰۷۷۰۷۷۶۰۴۰۲

**The Mitra Babak Show**  
**Runtime 25 minutes (DVD PAL)**





**Seminars on Couple therapy for Immigrants living in the UK  
14<sup>th</sup> and 15<sup>th</sup> June 2014**



**International Refugee Week**  
**Saturday 14th June 2014**  
**Sunday 15th June 2014**

**RESCUE 4 CHILDREN & MITRA BABAK PROUDLY  
PRESENT TWO SEMINAR SESSIONS DURING  
INTERNATIONAL REFUGEE WEEK 2014**

[www.mitrababak.com](http://www.mitrababak.com)  
[www.rescue4children.org](http://www.rescue4children.org)

Please RSVP to: [info@rescue4children.org](mailto:info@rescue4children.org)  
Address: Bootstrap, 18 Ashwin St, Hackney,  
Greater London E8 3DL

**Training Seminar on Couple therapy and importance of role play for immigrant and displaced communities living in refugee camps.**  
**28/03/2015**



Articles by Mitra Babak on various topics

<p>Ms. Mitra Babak Specialist Consultant Psychotherapist &amp; Researcher</p>  <p>Manoto+ Weekly Programs متن برنامه های هفتگی خاتم میترا بابک در من و تو +</p>  <p><a href="http://WWW.MITRABABAK.COM">WWW.MITRABABAK.COM</a> <a href="http://WWW.FACEBOOK.COM/MITRABABAKPAGE">WWW.FACEBOOK.COM/MITRABABAKPAGE</a></p> <p><b>Distance Marriage</b> ازدواج از راه دور</p> <p><a href="http://WWW.FACEBOOK.COM/MITRABABAKPAGE">WWW.FACEBOOK.COM/MITRABABAKPAGE</a> <a href="http://WWW.MITRABABAK.COM">WWW.MITRABABAK.COM</a></p>	<p>Ms. Mitra Babak Specialist Consultant Psychotherapist &amp; Researcher</p>  <p>Manoto+ Weekly Programs متن برنامه های هفتگی خاتم میترا بابک در من و تو +</p>  <p><a href="http://WWW.MITRABABAK.COM">WWW.MITRABABAK.COM</a> <a href="http://WWW.FACEBOOK.COM/MITRABABAKPAGE">WWW.FACEBOOK.COM/MITRABABAKPAGE</a></p> <p><b>Internet Dating Parts 1 and 2</b> ملاقات های اینترنتی قسمت ۱ و ۲</p> <p><a href="http://WWW.FACEBOOK.COM/MITRABABAKPAGE">WWW.FACEBOOK.COM/MITRABABAKPAGE</a> <a href="http://WWW.MITRABABAK.COM">WWW.MITRABABAK.COM</a></p>
<p>Ms. Mitra Babak Specialist Consultant Psychotherapist &amp; Researcher</p>  <p>Manoto+ Weekly Programs متن برنامه های هفتگی خاتم میترا بابک در من و تو +</p>  <p><a href="http://WWW.MITRABABAK.COM">WWW.MITRABABAK.COM</a> <a href="http://WWW.FACEBOOK.COM/MITRABABAKPAGE">WWW.FACEBOOK.COM/MITRABABAKPAGE</a></p> <p><b>Dating Part 2</b> تجربه اولیه قرار ملاقات قسمت ۲</p> <p><a href="http://WWW.FACEBOOK.COM/MITRABABAKPAGE">WWW.FACEBOOK.COM/MITRABABAKPAGE</a> <a href="http://WWW.MITRABABAK.COM">WWW.MITRABABAK.COM</a></p>	<p>Ms. Mitra Babak Specialist Consultant Psychotherapist &amp; Researcher</p>  <p>Manoto+ Weekly Programs متن برنامه های هفتگی خاتم میترا بابک در من و تو +</p>  <p><a href="http://WWW.MITRABABAK.COM">WWW.MITRABABAK.COM</a> <a href="http://WWW.FACEBOOK.COM/MITRABABAKPAGE">WWW.FACEBOOK.COM/MITRABABAKPAGE</a></p> <p><b>Love Failure Part 3</b> شکست عشقی قسمت ۳</p> <p><a href="http://WWW.FACEBOOK.COM/MITRABABAKPAGE">WWW.FACEBOOK.COM/MITRABABAKPAGE</a> <a href="http://WWW.MITRABABAK.COM">WWW.MITRABABAK.COM</a></p>



## Article on How to deal with Fear and Anxiety Published in Iranian Newspaper

کیهان

### چگونه با اندوه ناشی از مرگ عزیزان کنار بیاییم؟



میترا بایک

Mitra.bakhshizadeh@outlook

شده نه تنها سالگرد مرگ بلکه سالگرد ازدواج و یا تولد متوفی نیز لحظات عمیق برای شخص سوگوار است و گذشتن وقت در کنار سوگوار در این ایام می تواند کمک شایسته به وی کند. فراموشی نظیر نفاذت کردن، خریدهای روزمره، نگهداری از بچه ها می تواند برای او دوش سوگواران برآورد. برای سوگواران سلامت روح خود را دست نداشتن کمکهای نظیر کارهای منزل، تربیت دادن برادری، صورتبندیها و فشن های بدن، سرورس و تسکین کردن ماضی آنها عامل موثری در کاهش غم آنها خواهد بود. ۷. بالاخره اهمیت دارد که زمان کافی به افراد سوگوار داده شود تا خود یا غیر خود کنار آیند. عداوتی سریع کنار می آیند و برخی به زمان بیشتری نیاز دارند لذا نایبستی از این دوست و اقوام انتظار بیشتری داشت.

#### خود یاری در هنگام سوگواری

۱. توانمات و انتظارات از خودم را کاهش دهید. قبول کنید که در این زمان دشواری می توان دچار خطا شد و نظیر دیگری را از دست داد.
۲. از خود مراقبت کنید. کمبود خواب و تغذیه نامرست عیونت سیستم دفاعی بدن را در مقابل بیماری کاهش دهد و مسائل متعدد ایجاد نماید.
۳. ورزش منظم حتی اگر یک ربعی باشد ضرورتی است.
۴. از مشروبات الکلی که می تواند در کوتاه مدت کمک کوچکی باشد ولی عواقب و مضایب زیادی برای آینده ایجاد می کند دوری ورزید.
۵. از فرس های خواب دوری کنید.

قبول و قناعت و آغاز زندگی جدید است شروع می شود در این مرحله انفرادی پازل پاره خراب منظم شده و شخص با انرژی کامل به زندگی جاری باز می گردد. نیازهای جنسی که احتمالاً مدتها بی رنگ شده بود رنگ می گیرد. از این تغییر نایبستی احساس شرم نمود. بلکه نایبستی این احساس را تقویت نمود قبول واقعیتها به پذیرش فقدان ایجاد شده کمک می کند و راه رسیدن به مرحله نهایی که زمانی از سوگواری است هموار می گردد. در اینجاست که سازگاری مجدد و رشد شخصیت آغاز شده و افراد به روند زندگی طبیعی و سالم خود باز می گردند.

لازم به ذکر است که سوگواری برای همه یکسان نیست هر کس با ویژگیهای خود را دارد و نحوه برخورد هر کس با سوگواری می تواند متفاوت باشد. علاوه بر این گسترش با فرهنگ متفاوت، برخورداری متفاوتی با سوگواری و مرگ دارند. در بعضی از انواع مرگ صورت قسمتی از یک زندگی متداول نیست نه پایداری برای زندگی. عداوتی حواس سوگواری را در ملأ عام و عداوتی صورت خصوصی تحمل می دهند. در بعضی از انواع مرگ سوگواری، مصیبت شده است و مدت سوگواری، عموماً تغییر سوگواری در سایر انواع مرگ وجود دارد و بی میل آن می تواند متفاوت باشد. کودکان و جوانان اگر چه تا سه یا چهار سالگی مفهوم مرگ را درک نمی کنند ولی فقدان هر چیزی را در همان بزرگسالان حس می کنند. بطور وضوح دیده شده است که حتی کودکان شیرخوار نیز غم را حس می کنند و آنان که کمی بزرگتر هستند دچار دل درد، سر درد، خستگی، گرسنگی و خواب خود را با بی خوابی می شوند. کودکان بزرگتر دچار عصبانیت و بی قراری عصبی می شوند آنچه که گاهی مشهود است این است که نوجوانان دوران سوگواری را با سرعت بیشتری پشت سر می گذرانند.

کودکان حساسی گاهی دچار این نوع می شوند که آنها مسئول مرگ آن عزیز بودند. اینان نیازمند مراقبت هستند و نایبستی به آنها اطمینان و آرامش بحتیبت جوانان معمولاً از غم خود صحبت نمی کنند تا باعث افزایش غم دیگران نگردند. غم و اندوه کودکان و نوجوانان نایبستی نادرید گرفته شود و به بیار آنها برای سوگواری نایبستی توجه کافی کرد و مثلاً بهتر است اجازه داده شود تا آنها در مراسم دفن و گن حضور داشته باشند. در جوامعی که دفن و گن عداوت یا شهادت، آزار، قتل است

میترا بایک روانکاو و مشاور خانواده و مطبعت انگلستان است. وی ضمن پیش از ده سال همکاری با سازمان ملی بهداشت انگلستان (NHS) کوشش نموده است تا با ایرانیان مطبعت انگلستان را از حل مشکلات خانوادگی و معضلات اجتماعی آری دهد. همچنین با ایجاد سمینارها و کلاس های خود شناسی (F.E.P.P) سعی نموده است تا خانواده های ایرانی بخصوص نوجوانان را با فضایل و چالش های قسمت زیادی از آنها نایبستی از زندگی در دو فرهنگ متفاوت آشنا و برای خلق آمدن بر آنها آان را آموزش دهد. میترا بایک کمکهای خود را تنها برای ایرانیان انگلستان محدود نموده بلکه عموماً مهاجرینی که از خارج میانه به انگلستان کوچ کرده اند نیز مورد نظر وی بوده اند.

از دست رفته شده شناسن شده و خود و دیگران را مقصر این فقدان می دانند. عداوتی نیز از خود عزیزان دست رفته شناسن می شوند که چرا از خود می توان بیشتری نندوده است و چرا اصلاً وی می بایستی می بود؟ برخی نیز حس خود را منوجه خوانند و عداوتی تمام مقدمات می کنند. در هر حال مرگ و عداوتی قطع و این مرحله نیز مانند سایر مراحل دیگر بسیار طبیعی و گذرا می باشد.

احساس گناه احساس گناه بدیده دیگر است که در افراد ظاهر می شود. از اینکه کارهایی که بایستی انجام می دادند نداشتند و یا حرفهایی که بایستی گفته می شدند نگفتند و یا کارهایی می توانستند انجام دهند تا از مرگ آن عزیز جلوگیری نمایند ولی نگذاشتند دچار احساس گناه می شوند. حال آنکه همانطور که اشاره شد مرگ واقعی است که نمی بایست به وقوع می پیوست.

افسردگی: افسردگی و اضطراب احساس دیگری است که برای یکی دو هفته اول ادامه می یابد و پس از آن دوران غم و انرژی عصبی و سنگوت آغاز می شود. این تغییرات ناگهانی و نایبست احساسی روند طبیعی گذشت از مراحل سوگواری است. هر گذاره که احساس افسردگی افراد کاهش می یابد احساس غم و عداوتی آنها قزاقی یافته و طرف چهره ناخوش هفته پس از مرگ عزیزانش به عداوتی می رسد. پس از آن سر هر چند که عداوتی و عداوتی می تواند مرگ آن عزیز را نایبستی و یادآوری نماید.

انزوای طبیعی افراد سوگوار از اینکه گاهی نمی تواند احساس غم خود را کنترل نموده و بطور ناگهانی و بدون دلیل شروع به گریه می کنند. شرم داشته سعی می کنند از سایرین دوری ورزند. در روزهای اول سوگواری این نوع برای دیگران به وجود می آید که افراد سوگوار بهیوده در گوشه های نشسته و وقت خود را به عداوتی می گذرانند. حال آنکه سوگواران در این مدت در فکر خود خاطرات خوش دست گذشته اند. در مرگند بهیوده

اندوه ناشی از مرگ عزیزان تجربه تلخ و دردناکی است که تقریباً هر انسانی در روز یا آن درگیر خواهد شد. امروزه ما بسیار کمتر از گذشته خود به مرگ فکر نموده و درباره آن سخن می گوئیم. برای گذشتن مرگ برادر، خواهر و قوام تجربه ای بود که از همان اول جوانی با آن روبرو می شد. در زندگی امروزه بهت حوالی تر شدن غیر معمولاً ما با این تجربه تلخ در دوره دیرتری روبرو می شویم ولی باید بپذیریم که چگونه با غم از دست دادن عزیزان کنار آمده و آن را تحمل کرده و به آن فائق آید. در هر صورت غم از دست دادن کسی که مورد علاقه و سلامت و امنیت است که رخ خواهد داد و ما بایستی فرا گیریم که چگونه با آن روبرو شویم.

از دست دادن هر چیزی به خصوص اگر مرگ عزیز باشد بسیار ضایع است. این غم یک احساس تنها نیست بلکه مجموعه ای از احساسات متفاوت است که متوالی اتفاق می افتد و متعاقبانه نمی توان وقوع آن را تسریع نموده و مدت غمگساری را کوتاه کرد.

تألیف سوگواری برای مرگ محبوبی است که مدتها وی را می شناختیم ولی نایبستی توجه داشت ما افرادی که فرزندشان قبل از زایل می میرد و یا فرزند خود را از زایل پس از زایل فرزند خود را از دست می دهیم نیز این غم به همان اندازه می تواند دردناک باشد. بدون شک ایام نیز نیاز به مرگ و مرادیت دارند.

مرگ برای غم بسیار دردناکی است که به طرق مختلف بر جسم و روان ما تأثیر می گذارد. این آثار می تواند صورت حساسی مغز، یا اختیاری گریستن، بی خوابی و یا بی نظمی در خواب، هشیار خون، بی اشتها، روتن مو و در بالونی بر دم ریختن نظیر ریود ماهانه باشد. عداوتی عداوتی و حساسی مغز و شایع برای نایبستی از غم گشت و شادی از سوگواری.

مرگ هر چیزی باعث آغاز گشت عمل شدیدی در بدن می شود. مقدار تولید استروئید طبیعی

# Article on Bereavement Published in Iranian Newspaper

کیهان

## چگونه با اندوه ناشی از مرگ عزیزان کنار بیائیم؟



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شده تنها سالگرد مرگ بلکه سرگذشت ازدواج و یا تولد متولی نیز لحظات عمیق برای شخص سوگوار است و گذشتن وقت در کنار سوگوار در این ایام می‌تواند کمک ناشی به وی کند.

فرهنگ‌های نظیر تفاوت کردن، خریدهای روزمره، نگهداری از بچه‌ها می‌تواند برای از دست سوگواران باردار برای سوگواران دافعه که روح خود را از دست نماندن کمک‌های نظیر کارهای منزل، تربیت دادن برانگیزد. صورت‌های و فشارهای پرداختن، سرور و تسکین کردن ماشین آنها عامل مؤثری در کاهش غم آنها خواهد بود.

۷- بالاخره اهمیت دارد که زمان کافی به فرد سوگوار داده شود تا خود را غم خود کنار بگذارد. اینده عمدتی سریع کنار می‌آید و برخی به زمان بیشتری نیاز دارند لذا بایستی از این دوستان و اقوام انتظار بیشتری داشت.

### خود یاری در هنگام سوگواری

- ۱- نواها و انتظارات از خودمان را کاهش دهیم. قبول کنیم که در این زمان دشوار می‌توان دچار خطا شد و نظم فکری را از دست داد.
- ۲- از خود مراقبت کنیم. کمبود خواب و تغذیه نادرست می‌تواند سیستم دفاعی بدن را در مقابل امراض کاهش دهد و مسائل متعدد ایجاد نماید.
- ۳- ورزش منظم حتی اگر یک رله‌یمنی باشد ضروریست.
- ۴- مشروبات الکلی که می‌تواند در کوتاه مدت کمک کوچکی باشد ولی عواقب و مضایق زیادی برای آینده ایجاد می‌کند دوری ورزیم.
- ۵- در فرس‌های خواب‌آور دیری

قبول واقعیت و آغاز زنده‌گی جدید است شروع می‌شود در این مرحله انفرادی یا با خانواده. خواب منظم شده و شخص با انرژی کامل به زندگی جاری باز می‌گردد. نیازهای جنسی که احتمالاً مدتها بی‌رنگ شده بود رنگ می‌گیرد. از این تغییر بایستی احساس شرم نمود بلکه بایستی این احساس را تقویت نمود قبول واقعیت‌ها به پذیرش فقدان ایجاد شده کمک می‌کند و راه رسیدن به مرحله نهایی که زمانی از سوگواری است هموار می‌گردد. در اینجاست که سرگرمی مجدد و رشد شخصیت آغاز شده و فرد به زندگی طبیعی و سالم خود بازمی‌گردد.

لازم به ذکر است که سوگواری برای همه یکسان نیست هر قدر که ویژگی‌های خود را دارد و نحوه برخورد هر کس با سوگواری می‌تواند متفاوت باشد. علاوه بر این گشای با فرهنگ متفاوت، برخوردی متفاوت با سوگواری و مرگ دارند. در بعضی از نوع مرگ صورت قسمتی از یک زندگی مداوم است نه پایی برای زندگی. عده‌ای مراسم سوگواری را از ملا، جام و عذای صورت خصوصی انجام می‌دهند. در بعضی از جامع مدت سوگواری معین شده است و در سایر انواع غیر سوگواری در همه فرهنگ‌ها وجود دارد و بی‌شک آن می‌تواند متفاوت باشد.

کودکان و خردسالان اگر چه تا سه یا چهار سالگی مفهوم مرگ را درک نمی‌کنند ولی فقدان هر عزیزی را حس می‌کنند. سوگواری در کودکان براساس حس می‌گردد. ظهور و صبح دریده شده است که حس کودکان شوخوار نیز غم را حس می‌کنند و آنال که کمی بزرگتر هستند دچار دل درد، سر درد، خستگی، گرسنگی و اضطراب خود و بی‌خوابی می‌شوند. کودکان با هم گریه می‌کنند و گاهی با هم گریه می‌کنند و گاهی با هم گریه می‌کنند و گاهی با هم گریه می‌کنند.

میترا بابک روانشناس و مشاور خانواده و متقرب انگلستان است. وی ضمن پیش از ده سال همکاری با سازمان ملی بهداشت انگلستان (NHS) کوشش نموده است تا ایرانیان متقرب انگلستان را در حل مشکلات خانواده‌ای و معضلات احساسی باری دهد. همچنین با ایجاد سمینارها و کارگاه‌های خود شناسی (J.P.E.P) سعی نموده است تا خانواده‌های ایرانی بخصوص نوجوانان را با مسائل مختلف که قسمت زیادی از آنها ناشی از زندگی در فرهنگ متفاوت است آشنا و برای فائق آمدن بر آنها را آموزش دهد. میترا بابک کمک‌های خود را تنها برای ایرانیان متقرب انگلستان محدود نموده بلکه همواره سعی می‌کند که از جابجایی به انگلستان کوچ کرده‌اند نیز مورد نظر وی بوده‌اند.

از دست رفتن از مرگ عزیزان تجربه و دردهای است که تقریباً هر انسانی در پارچه‌ای از عمر خود خواهد شد. امروزه مایوسگر کمتر از گذشتگان خود به مرگ فکر نموده و درباره آن سخن می‌گویند. برای گذشتگان مرگ برادر، خواهر و تمام تجربه‌ای بود که از همان اول جوانی با آن روبرو می‌شدند. در زندگی امروزه بدلت طولانی‌تر شدن عمر معمولاً ما با این تجربه تلخ در دوره شیرینی و روزه می‌شویم ولی باید ببینیم که چگونه با غم و دست دادن هر چیزی کنار آمده و آن را تحمل کرده و به آن فائق آید. هر چه صورت غم از دست دادن کسی که مورد علاقه ما است و باقی‌مانده است که رخ خواهد داد و ما بایستی از آن گریه کنیم که چگونه با آن روبرو شویم.

از دست دادن هر چیزی به‌خصوص اگر مرگ عزیز باشد بسیار دشوار است. این غم، یک احساس است. نیست بلکه مجموعه‌ای از احساسات و تکلیف‌هاست که رخ خواهد داد و ما بایستی از آن گریه کنیم که چگونه با آن روبرو شویم.

اگر مرگ عزیز باشد بسیار دشوار است. این غم، یک احساس است. نیست بلکه مجموعه‌ای از احساسات و تکلیف‌هاست که رخ خواهد داد و ما بایستی از آن گریه کنیم که چگونه با آن روبرو شویم.

**انفرادی: اشتیاق و اضطراب**  
احساسی دیگری است که برای یکی دو هفته اول ادامه می‌یابد و پس از آن دور غم و اندوه ملایم و سکونت آغاز می‌شود. این تغییرات ناگهانی و ناهنجاری‌ها احساسی روند طبیعی گذشت از مراحل سوگواری است. هر اندازه که احساس اشتیاقی افراد کاهش می‌یابد، احساس غم و غصه آنها قوی‌تر می‌گردد و طرف‌چهار ناشی می‌گردد. پس از آن نیز هر چه گذشت و حواس و حواس می‌تواند مرگ آن عزیز را نادیده و یادآوری نماید.

**انرواطی: افراد سوگوار از اینکه گاهی نمی‌توانند احساس غم خود را کنترل نموده و بطور ناگهانی و بدون دلیل شروع به گریه می‌کنند. شرم داشته سعی می‌کنند از سایرین دوری ورزند. در روزهای اول سوگواری این نوع برای دیگران به وجود می‌آید که افراد سوگوار بیهوده در گوشه‌ای نشسته و وقت خود را به طاعت می‌گذرانند. حال آنکه سوگواران در این مدت در فکر خود خاطرات خوش و بد گذشته اند. به مرگند و به**

انده ناشی از مرگ عزیزان تجربه و دردهای است که تقریباً هر انسانی در پارچه‌ای از عمر خود خواهد شد. امروزه مایوسگر کمتر از گذشتگان خود به مرگ فکر نموده و درباره آن سخن می‌گویند. برای گذشتگان مرگ برادر، خواهر و تمام تجربه‌ای بود که از همان اول جوانی با آن روبرو می‌شدند. در زندگی امروزه بدلت طولانی‌تر شدن عمر معمولاً ما با این تجربه تلخ در دوره شیرینی و روزه می‌شویم ولی باید ببینیم که چگونه با غم و دست دادن هر چیزی کنار آمده و آن را تحمل کرده و به آن فائق آید. هر چه صورت غم از دست دادن کسی که مورد علاقه ما است و باقی‌مانده است که رخ خواهد داد و ما بایستی از آن گریه کنیم که چگونه با آن روبرو شویم.

اگر مرگ عزیز باشد بسیار دشوار است. این غم، یک احساس است. نیست بلکه مجموعه‌ای از احساسات و تکلیف‌هاست که رخ خواهد داد و ما بایستی از آن گریه کنیم که چگونه با آن روبرو شویم.

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مرگ عزیزان غم بسیار دردناکی است که به طرق مختلف بر جسم و روان ما تأثیر می‌گذارد. این آثار می‌تواند بصورت خستگی مفرط، بی‌اشتیاقی، بی‌خوابی و یا بی‌نظمی در خواب، فشار خون، بی‌اشتیاقی، بی‌رزشی و در باطن بر می‌خیزد. نظم برپود مشاهده می‌شود. ضعف خول‌آلودگی و خستگی مفرط مشاهده‌ای باری ناشی از غصه‌است و نادری از سوگواری

مرگ هر عزیزی باعث آغاز یک عمل زندگی در بدن می‌شود. به مقدار تولید استروئید طبیعی



## Article on “The argument that if World Leaders received psychotherapy, how the world would be a different place”

4/13/2015

akhbare-rooz (Iranian political Bulletin)



پادادشت سیاسی | سیاسی | دیدگاه | ادبیات | زنان | جهان | بخش خبر | آرشیب | حقوق بشر | ورزش | اجتماعی | اقتصادی

### روان رهبران سلم باد

مینرا بابک، روانکاو - همین سیدی، تحلیلگر سیاسی

• نقش روان‌شناسی فردی، در زمانی که آن فرد یک شخصیت سیاسی است و از یک موقعیت خاص و قدرت ویژه برخوردار است، نیاز به توجه و بررسی بیشتر دارد. این بررسی دیرزمانی است که در سطح جهانی آغاز شده و تاریخ‌نگاران و روان‌شناسان به بررسی شخصیت فردی چهره‌های تأثیرگذار در تحولات جهان می‌پردازند...

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آئینه ۵ اردیبهشت ۱۳۹۲ - ۲۵ آوریل ۲۰۱۴

ایرانیان معمولاً به روحیات فردی رهبران سیاسی توجه ویژه دارند اما این توجه معمولاً از حد شوخی و طنز فراتر نمی‌رود. شاید به این دلیل که هیچ‌گاه فضای سیاسی برای ورود جدی به این عرصه فراهم نبوده است. پنبیده احمدی‌نژاد به آغاز دوره‌ای جدید از این طنزپردازی‌ها انجامید، بخشی به خاطر روحیات فردی احمدی نژاد و بخشی هم به این دلیل که او خود به بررسی امور شخصی دیگران، مخصوصاً مخالفانش علاقه‌مند بود. به عبارتی او خود سر این شوخی‌ها را باز کرد، آن هم با مخالفانی بسیار شوخ‌طبع. بازی خطرناکی بود.

اما فراتر از دنیای طنز و طعنه، نقش روان‌شناسی فردی، در زمانی که آن فرد یک شخصیت سیاسی است و از یک موقعیت خاص و قدرت ویژه برخوردار است، نیاز به توجه و بررسی بیشتر دارد. این بررسی دیرزمانی است که در سطح جهانی آغاز شده و تاریخ‌نگاران و روان‌شناسان به بررسی شخصیت فردی چهره‌های تأثیرگذار در تحولات جهان می‌پردازند. البته هدف آنها از این بررسی‌ها، تقلیل دادن همه تحولات سیاسی به روان‌شناسی رهبران سیاسی نیست بلکه این بررسی‌ها را تنها به عنوان یکی از سطوح بررسی انجام می‌دهند.

اصولاً می‌توان سه لایه متفاوت را برای بررسی تحولات سیاسی در نظر گرفت: نقش عوامل جهانی و منطقه‌ای، نقش عوامل داخلی و درون کشوری و نهایتاً، نقش افراد و رهبران که معمولاً نقشی تکمیلی یا تعدیل کننده را برای دو عامل دیگر دارند. در این نوشته، نخست، نگاهی مختصر به چند نمونه تاریخی از نقش و جایگاه افراد در تحولات بزرگ جهان انداخته، سپس به بررسی خلقیات و روحیات حاکمان اخیر ایران و تأثیر آنها بر روند تحولات سیاسی می‌پردازیم و در نهایت بر لزوم بازسازی روانی بازیگران سیاسی امروز ایران در داخل و خارج از کشور و اهمیت برخورداری آنها از سلامت روانی برای ایفای نقش مثبت در تحولات آینده تأکید می‌کنیم.

### اگر جهان رهبران سالمتری داشت

پیش از صد سال پیش آمریکا رئیس جمهوری داشت متفاوت با همه رئیس‌جمهورهای سابق و همچنین متفاوت با بسیاری از جانشینانش. وودرو ویلسون دانش آموخته حقوق و علوم سیاسی بود. شخصیتی آکادمیک که از ریاست دانشگاه به ریاست جمهوری آمریکا رسیده بود. نه تنها از حزب دمکرات بود بلکه عملاً دمکرات‌منشانه رفتار می‌کرد و ایده‌هایی لیبرالی داشت. او مبتکر 'اتحادیه ملل' در سال ۱۹۱۹ بود تا با درس گرفتن از تجارب جنگ جهانی اول، با همکاری کشورهای، از تکرار این فاجعه جلوگیری شود. او علناً به ایده رایج آن زمان- و شاید این زمان هم- یعنی ایده بالانس قدرت می‌تاخت و معتقد بود: تأکید بر نگه داشتن بالانس بین قدرتهای بزرگ، به نادیده گرفتن حقوق انسانها و ملتها خواهد انجامید، به جای آن، او بر همکاری همه قدرتهای کوچک و بزرگ تأکید داشت. اما علیرغم همه این خصایص خوب، ویلسون در مذاکرات و منازعات سیاسی، شخصیتی موفق نبود. او حتی نتوانست کنگره آمریکا را برای پیوستن این کشور به اتحادیه ملل قانع کند. او شخصیتی کمالگرا داشت که می‌بایست مخالفانش، همه ایده‌های او را قبول کنند و نه فقط بخشی از آن را. ویلسون دمکرات و لیبرال در عرصه سیاست جهانی، در شایب درونی خودش، قلدر و زورگو بود. در نهایت آمریکا به این اتحادیه جهانی نپیوست و بسیاری از تحلیل‌گران، یکی از دلایل ناکارایی این اتحادیه را که به جنگ جهانی دوم انجامید، در نپیوستن آمریکا می‌دانند. ویلسون علاوه بر قلدر بودن، ضعف دیگری هم داشت و آن اینکه از قدرت اقطاع بی‌بهره بود.

اما اصولاً چرا جنگی جهانی در گرفت که نیاز به اتحادی جهانی برای پیشگیری از تکرار آن باشد؟ در اینجا نیز سه سطح متفاوت و مکمل از تحلیل که در مقدمه به آنها اشاره شد، می‌توان ارایه داد که در این نوشته از بررسی سطح جهانی و سطح داخلی عوامل می‌گذریم و به نقش افراد می‌پردازیم. فرانس جوزف امبراطور اتریش و مجارستان، در آستانه جنگ جهانی اول، رهبری بیر و فرسوده بود که کاملاً تحت مدیریت ژنرالهای ارتش قرار گرفته بود. عملاً آنها سیاست خارجی را تعیین می‌کردند و بسیار مایل بودند جنگ افزارهای جدیدی را که تا کنون در هیچ جنگی به کار نبرده

چاپ کن

نظرات (۲)

نظر شما

اصل مطلب

بودند، امتحان کنند. متحد آنها، قیصر آلمان بود که او هم شخصیتی ضعیف و تحقیر شده داشت و همزمان بسیار هم عاطفی و احساسی بود. در کابینه او وزیر خارجه ای زورگو نقش اصلی را داشت. محققانی که پس از جنگ به بررسی اسناد وزارت خارجه آلمان پرداخته‌اند، متوجه شدند که تقریباً همه دیپلماتهای آلمانی، راجع به واکنش کشورهای همسایه به سیاستهای آلمان، گزارش‌های دروغی را تحویل او داده بودند. همه آن دیپلماتها می‌دانستند که جناب وزیر تحمل شنیدن گزارشهایی را که بر خلاف میل و خط سیاسی او باشند را ندارد. همه، تنها آن چیزهایی را که می‌پسندید، به او گزارش می‌دادند.

در مواردی دیگر مرگ یا جابه‌جایی شخصیت‌های سیاسی که ظاهراً با هم همفکر بودند، باعث تغییر مسیرهای تاریخی شده‌اند، چرا که آنها علی‌رغم تشابه‌های ظاهری، دارای خصلت‌های درونی متفاوتی بودند. مرگ روزولت رئیس‌جمهور آمریکا تنها یک ماه مانده به پایان جنگ دوم جهانی، تأثیر بسیاری بر روابط دو قدرت جهانی داشت که نهایتاً به جنگ سرد انجامید. روزولت در دوران جنگ دوم، روابط و همکاری مناسبی با شوروی داشت و تا زمان مرگش، ماه آوریل سال ۱۹۴۵، این روابط را ادامه داد، اما جانشین او، ترومن چنین سیاستی را در پیش نگرفت و تنها دو ماه پس از پایان جنگ در کنفرانس ماه جولای پوتسدام، به صورت تلویحی شوروی را با بمب اتمی تهدید کرد. علی‌رغم هم‌حزبی بودن با روزولت، گرایش مذهبی و بستر آموزش خانوادگی ترومن با روزولت بسیار متفاوت بود. این تفاوت در شخصیت دو رئیس‌جمهور در دوران جانشین و کندی هم تکرار شد. پس از ترور جان اف کندی، جانسون معاون او به عنوان جانشینش انتخاب شد که هر دو از حزب دمکرات بودند. جنگ ویتنام در دوران جانسون شروع شد. شماری از پژوهشگران تاریخ جنگ ویتنام، با بازسازی شرایط مشابه سیاسی، به این نتیجه رسیده‌اند که کندی در دوران کوتاه ریاست جمهوری خود، چهار بار در موقعیتی مشابه با جنگ ویتنام قرار گرفت، اما بر خلاف جانسون، هیچ‌گاه اجازه ورود آمریکا به این جنگ‌ها را صادر نکرد.

در این جا به بررسی احتمال تفاوت‌های دو شخصیت از دو حزب متفاوت نمی‌پردازیم که اگر مثلاً ال گور در سال دو هزار به جای جورج بوش انتخاب می‌شد آیا به عراق حمله می‌کرد یا اگر میت رامنی به جای اوباما رئیس‌جمهور می‌شد، سیاست آمریکا در قبال ایران چگونه می‌شد.

#### اگر ایران رهبران سالمی داشت

به گذشته‌های دور نمی‌پردازیم. در دوره تاریخ معاصر هم، از بررسی شخصیت پدر و پسر پهلوی می‌گذریم و تنها به این نکته قناعت می‌کنیم که حتی دوستدارانشان هم افسوس می‌خورند که کاش آن پدر، کمی اهل مدارا و احترام به قانون بود و آن پسر هم، شخصیتی قوی و اعتماد به نفس کافی داشت. در اینجا تنها به بررسی نقش رهبران جمهوری اسلامی و گزینه‌های دیگری که احتمال رهبر شدن داشتند، می‌پردازیم ولی قبل از آن باید مجدداً بر نقش روابط بین المللی و معادلات جهانی و همچنین عوامل اجتماعی و داخلی در سرنوشت این حکومت تأکید کنیم و در این نوشته، فقط به عنوان عنصر تکمیلی، به بررسی نقش 'فرد' در جایگاه رهبران جمهوری اسلامی می‌پردازیم.

فرصتی تاریخی برای خمینی فراهم شده بود که به شخصیتی محبوب و جهانی تبدیل شود. شاید در حد ماندلا و گاندی و ... اما، هم این فرصت را از خود گرفت و هم انقلاب مردم را به بیراهه کشاند. خمینی به خاطر ساده‌پستی، پافشاری بر مبارزه، سالها زندگی در تبعید و جایگاه ویژه مذهبی‌اش، در بین قشر ثابتهای مردم نفوذ داشت و مواضع لیبرال و دمکرات‌منشانه‌اش، مخصوصاً مصاحبه‌های پاریس که در آن به صراحت از حقوق بشر و 'حقوق واجد ملی' و آزادی بیان برای مردم ایران سخن گفته بود، توجه قشرهای دیگر جامعه را هم به خود جذب کرد. اما در واقع این برتری طلبی او بود که با ماسک مهر طلبی، در پاریس سخن می‌گفت، نه خود او. گذشته او مجالی برای مهربانی نگذاشته بود. خمینی در آغاز به قدرت رسیدن رضاشاه، یک طلبه جوان و ساده بود و در پایان زمانداری او، یک حجه‌الاسلام پر از کینه و نفرت از همه مظاهر جهان مدرن، مخصوصاً آن بخشی که به زور به جامعه تحمیل شده بود و در رأس همه، مساله کشف حجاب که مستقیماً به اعتقاداتش مرتبط بود. او این کینه را برای همیشه در دل خود نگه داشت حتی آن زمان که از آزادی و حقوق برابر حرف می‌زد. برخوردهایی هم که مستقیماً علیه او انجام می‌شد و 'من' او را تحقیر کرده بود، بخش دیگری از مشکلات او را تشکیل می‌داد. تأکید بسیار زیاد بر نهاد 'من' در اولین سخنرانی پس از بازگشتش (من دولت تعیین می‌کنم، من تو ذهن این دولت می‌زنم، من...) حکایت از 'من'ی تحقیر شده و خودشیفته‌اش داشت که اکنون مجالی برای انتقام‌جویی یافته بود. تحقیرهایی به مراتب شدیدتر، هیچ‌گاه برای روان سالم ماندلا چنین 'من' بزرگی نداشت. ماندلا حتی دشمنانش را قربانی سیستم حاکم می‌دانست اما خمینی، سیستم را، محصول دشمنانش می‌دانست و از آنها متنفر بود. مشکل درونی خمینی تنها به این مسائل ختم نمی‌شد. برخلاف ظاهر قوی و ثبات رایی که از خود نشان می‌داد، بسیار وابسته به نظر اطرافیان هم بود. او در مواردی بسیار مهم، به راحتی تحت تأثیر احساسات نزدیکانش قرار می‌گرفت. با نگاهی دقیق به یادداشت‌ها و خاطرات افرادی که جزو نزدیکان خمینی محسوب می‌شدند، معلوم می‌شود که این افراد یا مستقیماً بر او تأثیر می‌گذاشتند، یا به صورت غیرمستقیم، توسط فرزندش، احمد، نظرات خود را به او القا می‌کردند. خمینی در موارد بسیار مهمی از جمله تشکیل حزب جمهوری اسلامی، حضور روحانیون در پست ریاست جمهوری، حمایت از اشغال سفارت آمریکا، ادامه جنگ با عراق، و خیلی موارد مهم دیگر، تحت تأثیر آنها، از مواضع اولیه‌اش عدول کرد. او یا به خاطر کهولت سن و یا به علت خصلت درونی، نمی‌توانست در برابر کسانی که با آنها رابطه عاطفی داشت، مقاومت کند و به تدریج به خواسته‌های آنها تن می‌داد.

شاید آخرین مورد آن، عزل قائم مقام خود، منتظری در فروردین ۱۳۶۸ چند ماه قبل از فوتش بود. اگر حتی سرنوشت انقلاب ایران را خارج از اراده فردها، همین جمهوری اسلامی و همین قانون اساسی نادمکراتیک و همین دهه شصت مملو از کشتار فرض کنیم، حداقل پس از مرگ خمینی، می‌شد شاهد جمهوری اسلامی متفاوتی باشیم، اگر به جای خامنه‌ای، منتظری رهبر ایران می‌شد.

تفاوت‌های شخصیتی این دو را شاید بتوان با بررسی کلید-واژه‌های آنها بهتر متوجه شد. واژه‌های تهاجم، دشمن و جنگ، بیشترین کاربرد را در سخنان خامنه‌ای دارند در حالی که منتظری را می‌توان با واژه‌های وحدت، حقوق، و عفو شناخت. هرچند هیچ کدام از ایده‌های منتظری مجال اجرا و رشد نیافتند اما همه، نشان از روان سالمتر این فرد داشتند. در اوج قدر قدرتی یک حکومت شیعی، او بر لزوم وحدت شیعه و سنی تأکید می‌کرد، در حالی که نیروهای مخالف یکی از پس از دیگری حذف فیزیکی می‌شدند، منتظری طرح عفو مخالفان را ارائه می‌داد (که البته این طرح برای مدتی در قالب اعطای امان نامه اجرا شد) و در شرایطی که خیلی از مسلمانها هم حقوقشان پایمال می‌شد، او از حقوق غیرمسلمانان دفاع می‌کرد و معتقد بود که آنها هم حق آب و گل دارند در این کشور. فرض کنید که همین جمهوری اسلامی، به مدت بیست سال، از مرگ خمینی تا مرگ منتظری، توسط او و یا طالقانی رهبری می‌شد، آیا باز همین شرایط و همین سیستم حکومتی که الان شاهدش هستیم حاکم بود؟ تنها اتهامی که به منتظری وارد بود، همان ساده بودن بود. تنها در دنیای ناسالم سیاسی، سادگی او، یک ضعف محسوب می‌شود. حتی اگر آن را به عنوان یک نکته منفی هم بپذیریم، باز به مراتب از کینه‌ای بودن، برتری طلب بودن، اجبار بودن و غرق در توهم دشمن بودن بهتر است.

#### رهبران آینده را دریابید

روانشناسی فردی تنها رهبران درون حلقه قدرت را در بر نمی‌گیرد، به نحوی شاید شدیدتر شامل رهبران مخالفان هم می‌شود. برخوردار نبودن از روانی سالم و آسیب‌پذیری شخصیتی در مورد آنها، ممکن است خطرناکتر هم باشد، چون آسیبها، تنها به دوران کودکی و شکلگیری شخصیت فردیشان محدود نمی‌شود. آنها ممکن است در دوران اپوزیسیون بودن و در دوران زندان و تبعید و ... در شرایط بدتری هم قرار گرفته باشند و آسیب‌های بیشتری را متحمل شده باشند. هر چه این دوران پر از عصبیت و تنش، طولانی تر بوده باشد، خطرات و آسیبهای وارده می‌تواند شدیدتر باشد. البته برای کسانی که از نخست از روانی سالم برخوردار بوده‌اند، این دشواریها ممکن است باعث پختگی بیشتر و قوی‌تر شدن شخصیت‌ها بشود، اما با نگاهی اجمالی به طیفهای مختلف اپوزیسیون، متأسفانه معلوم می‌شود که شمار قربانیان و آسیب‌دیدگان، از شمار کسانی که قوی‌تر و کارآمدتر شده‌اند، بیشتر است. حال تصور کنید که تغییر و تحولی ناگهانی صورت گیرد و این افراد که خود قربانی هستند و نیاز به کمک کارشناسی و مشاوره دارند، متصدی امور شوند و رهبری مردم یا بخشی از مردم را به دست بگیرند.

هشدار! تمامی کسانی که در جوامع بسته و خانواده‌های سنتی بزرگ شده‌اند، نیاز به خودشناسی و آسیب‌شناسی شخصی و در نهایت، اصلاح و ترمیم روان خود دارند و این نیاز برای سیاستمدارها ضروری‌تر است. واقعیت تلخی است که اکثر ما نه در خانواده‌ای با اصول درست پرورش، بزرگ شده‌ایم، نه در مدارس سالم و اصولی آموزش دیده‌ایم (در هر دو دوره پهلوی و اسلامی) و نه جامعه، برخوردهای درست و اصولی را به ما یاد داده است. باید در هر سن و مقطعی که هستیم، خودمان به داد خودمان برسیم و آنچه را که نیاموخته‌ایم، بیاموزیم. مراجعه به روانشناس و مشاور خانوادگی و امور شخصی، به مانند مراجعه به دندانپزشک و دکتر خانوادگی ضروری است اما چون در مورد سیاستمدارها، عواقب مثبت و منفی افکار و اعمالشان، تنها شامل افراد خانواده و جمع اندکی از اطرافیانسان نمی‌شود و ممکن است میلیونها انسان از ندانم‌کاری‌ها و یا برعکس، از طرحها و برنامه‌های مفید آنها متاثر شوند، گرفتن کمک کارشناسی از روانشناسان و مشاوران خانواده ضروری تر است. آنها می‌توانند با یافتن نقاط ضعف و قوت خود و کار کردن روی آنها، طی مدت چند ماه به نتایج درخشانی برسند، البته به شرطی که نخست بپذیرند که مریض و آسیب دیده هستند و نیاز به کمک دارند و اصلاً به فکر اصلاح روانشناسان خود یا جذب آنها به حزب خودشان نباشند! آنها همچنین با این اقدام خویش می‌توانند به ترویج فرهنگ مراجعه به روانشناس در میان مردم و کسانی که آنها را الگو و سرمشق خود می‌دانند، کمک کنند. به تدریج فضایی ساخته می‌شود که نه تنها داشتن پرونده ترابی وضعی محسوب نمی‌شود که برعکس، به یکی از نقاط قوت افراد تبدیل شده و نشان‌دهنده میزان توجه آنها به سلامت روحی و روانی خودشان تلقی می‌گردد، زیرا که خودشناسی، دیگر شناسی را هم در پی دارد.

\* ویژه اخبار روز

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